MICHAEL R. PENCE, Governor
STATE OF INDIANA

INDIANA DEPARTMENT OF HOMELAND SECURITY
302 West Washington Street
Indianapolis, IN 46204

EMERGENCY MEDICAL SERVICES

COMMISSION MEETING MINUTES

DATE: **June 20, 2014**

LOCATION: **Seyl Auditorium**
Northlake Campus
600 Grant Street
Gary, IN 46402

MEMBERS PRESENT:	John Zartman	(Training Institution)
	Charles Valentine	(Municipal Fire)
	Myron Mackey	(EMTs)
	Terri Hamilton	(Volunteer EMS)
	Mike Garvey	(Indiana State EMS Director)
	Michael Lockard	(General Public)
	Sue Dunham	(Emergency Nurses)
	Michael Olinger	(Trauma Physicians)
MEMBERS ABSENT:	Melanie Jane Craigin	(Hospital EMS)
	G. Lee Turpen II	(Private Ambulance)
	Darin Hoggatt	(Paramedics)
	Stephen Champion	(Medical Doctor)

OTHERS PRESENT: Field Staff (Robin Stump, Don Watson, Steve Gressmire and Jason Smith), Candice Hilton, Elizabeth Westfall, and members of the EMS Community

CALL TO ORDER AND ROLL CALL

Meeting called to order at 10:06 am by Vice Chairman Charles Valentine.

Candice Hilton called roll and announced quorum.

Dr. Nick Johnson, associate Medical Director for Methodist, welcomed everyone to the facility.

ADOPTION OF MINUTES

A motion was made by Commissioner Mackey to table the minutes from the April 25, 2014 meeting. The motion was seconded by Commissioner Lockard. The motion passed to table the minutes until the next meeting.

A motion was made by Commissioner Mackey to amend the minutes from the December 20, 2013 meeting to reflect Primary Instructors in the motion original motion in regards to the attendance of the PI/Training Institution updates. The motion was seconded by Commissioner Zartman. The motion passed.

A motion was made by Commissioner Mackey to include splinting of extremities excluding traction splinting to the Emergency Medical Responder scope of practice. Splinting was excluded from the previously approved EMR skills. The motion was seconded by Commissioner Zartman. The motion passed.

INDIANA DEPARTMENT OF HEALTH

Mr. Art Logsdon asked for the Commission to approve the following ACS in process hospitals:

Good Samaritan Hospital of Vincennes

Community Hospital of Anderson

A motion was made by Commissioner Zartman to approve both hospitals to be ASC in process hospitals. The motion was seconded by Commissioner Lockard. The motion passed.

Commissioner Lockard asked how many hospitals are currently approved to be "in process". Mr. Logsdon stated that there are currently six "in process" hospitals.

Mr. Logsdon began a discussion regarding a midterm reporting process for the "in process" hospitals. The Health Department wants to make sure that at the one year mark the hospitals are on track. Commissioner Olinger asked if the Commission has the authority to grant Mr. Logsdon's request. Legal Counsel Mara Snyder suggested Commission staff send a letter requesting the progress of the hospital be sent to the Indiana Department of Health. She also stated that if the hospitals do not respond they will need to answer to the Commission as to why they didn't respond.

A motion was made by Commissioner Olinger to have staff draft and send a letter requesting a report on the progress at the one year mark for the "in process" hospitals. The motion was seconded by Commissioner Hamilton. The motion passed.

Mr. Art Logsdon reported out regarding the data report (see attachment #1).

EMS FOR CHILDREN REPORT

Ms. Candice Hilton reported the following information for Gretchen Huffman:

The recommendations for equipment on ambulances have changed and Ms Huffman is reanalyzing the data we collected and will present it at the next meeting.

TECHNICAL ADVISORY COMMITTEE

Technical Advisory Committee Chairman Leon Bell presented the Technical Advisory Committee recommendations:

1. Advance EMT continuing education-
   The TAC reviewed their previously recommended continuing education requirements of 72 hours. After reviewing all the information that the TAC could find regard the continuing education hours for the National Registry they could not find anything that said there would defiantly be changes to the categories or hours for the National Registry requirements. The TAC is staying with their original recommendation (see attachment #2) regarding the AEMT continuing education hours and make it effective July 1, 2014.

A motion was made by Commissioner Zartman to accept the TAC's recommendation. The motion was seconded by Commissioner Hamilton. Discussion followed regarding the emergency rules and the current requirements. Commissioner Zartman amended his original motion to take out July 1st and add when the emergency rules become final. The amendment was seconded by Commissioner Hamilton. The motion passed.

2. Proposed rules and regulations for the Advance EMT Provider Organizations (see attachment #3).

A motion was made by Commissioner Olinger to table the proposed rules and regulations for the AEMT Provider Organization level until the August meeting to give the Commission members time to review the documents. The motion was seconded by Commissioner Zartman. The motion passed.

3. Primary Instructor Manual
   TAC Chairman Bell reported on the discussion, findings, and recommendations from the TAC to the EMS Commission in regards to the Primary Instructor Manual. After some research the TAC found that the Commission had voted and approved the mandating of attendance for the PI/TI updates but had not voted on the manual itself. The TAC divided the manual into four sections. The TAC endorses the paid representative system in Indiana but recognizes that funding has to be found for the program first. There are things in section one of the manual that will need rules written therefore the TAC is recommending that a specialized sub group be formed to look at section one of the manual. Section 2 of the manual deals with the psychomotor examination process. The TAC is recommending the adoption of Section 2 as reviewed and revised by the TAC (see attachment #4).

A motion was made by Commissioner Zartman made a motion to create the group for reviewing section 1 of the Primary Instructor Manual. The group would consist of Ms. Elizabeth Westfall and Ms. Robin Stump from staff, Mr. Jeff Quinn and Mr. Kraig Kenney from the Education Work Group, Ms. Sherry Fetters and Mrs. Jessica Lawley from the TAC, and Commissioner Hamilton. The motion was seconded by Commissioner Mackey. The motion passed.

A motion was made by Commissioner Zartman to accept section 2 as reviewed and revised by the Technical Advisory Committee. The motion was seconded by Commissioner Mackey. Discussion followed. Director Mike Garvey stated he wanted to make sure that the Commission understood what they are voting on and what exactly they are voting on. Chairman Bell explained the changes to the random skills station. Commissioner Hamilton stated that the word make up needs to be changed to moulage in a couple of places. The motion passed.

4. Telephone conference
   Chairman Bell requested that a motion be prepared to enable the Technical Advisory Committee to use telephone conferences or video call by Committee members in order to ensure a quorum. Director Garvey stated that staff will draft a policy to be adopted at the August meeting.

INDIANA EMERGENCY MEDICAL SERVICES ASSOCIATION

Mr. George Schulp reported for the IEMSA. Mr. Schulp stated that the conference on May1st and 2nd was successful. The association has started planning for next year's conference. Mr. Schulp also announced the upcoming motorcycle ride in July for Supporting Heroes. Tom Bettenhausen spoke about the ride as well stating that the organization comes in to help families of fallen public safety workers. Mr. Schulp stated that the new public safety announcements are ready for release. They are currently on utube and on the Indiana Emergency Medical Services Association Facebook page.

PERSONNEL WAIVER REQUESTS

The following requested a waiver of 836 IAC 4-4-1 (b) The applicant shall apply for certification on forms provided by the agency postmarked within one (1) year of the date that the course was concluded as shown on the course report. John is asking for a waiver of the one year date. John completed a course in 2011 and did not test. Completed another course in 2013, took written 11-6-2013 and failed and has not attempted again. Staff Recommends denial.

John Bowers EMT

A motion was made by Commissioner Zartman to deny the waiver request. The motion was seconded by Commissioner Hamilton. Discussion followed. Commissioner Zartman withdrew his motion. A motion was made by Commissioner Mackey to accept Mr. Bowers' written exam which was taken and passed outside of his one year time limit. The motion was seconded by Commissioner Olinger. The motion passed.

The following requested a waiver of Emergency Rule LSA Document #12-393E Section 47 Based on the rules state a registered nurse may challenge the emergency medical technician-intermediate course if he or she meets the following requirements: (1) Be a registered nurse in Indiana. (2) Be an Indiana certified emergency medical technician. (3) Be able to document one (1) year of experience in an emergency department or as a flight nurse with an air ambulance service. (4) Hold an advanced cardiac life support certification. (5) Hold either an American Heart Association or American Red Cross health care provider card or equivalent. (6) Be able to meet prerequisites required by the commission, the emergency medical technician-intermediate curriculum, and the local training institution course. Staff Recommends denial. Brenda states she is a LPN and the rules only speak of a RN.

Brenda Gridley EMT Basic Advance

A motion was made by Commissioner Zartman to deny the waiver request. The motion was seconded by Commissioner Hamilton. The motion passed to deny the waiver.

The following requested a waiver of 836 IAC 4-3-2 Certification standards First Responder Paul is asking for a waiver of time to turn in his hours. First Responder expires 9-30-2013. Staff recommends denial.

Paul Laswell EMR

A motion was made by Commissioner Hamilton to deny the waiver request. The motion was seconded by Commissioner Zartman. Discussion followed. Commissioner Hamilton amended her motion to grant the waiver request with the stipulation that Mr. Laswell take the written and practical exams and pass in one attempt within sixty (60) days. The motion was seconded by Commissioner Zartman. Commissioner Mackey wanted to clarify that Mr. Laswell did complete his continuing education on time it was just never approved. The motion passed.

PROVIDER WAIVER REQUESTS

The following requested a waiver of 836 IAC 2-7.2-3 Emergency medical technician-intermediate provider organization operating procedures Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20 Affected: IC 16-31-3 (B) Endotracheal intubation devices, including the following: (i) Laryngoscope with extra batteries and bulbs. (ii) Laryngoscope blades (adult and pediatric, curved and straight). (iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter. (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate. (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa) albuterol; (bb) ipratropium; (cc) isoetharine; (dd) metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v) Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii) Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate. (xiv) Naloxone. (xv) Nitroglycerin. Aurora Emergency Rescue is requesting a waiver of the medications in 836 IAC 2-7.2-3 in the Intermediate rules. Aurora Emergency Rescue has new ADV EMTs and are moving to the ALS level. Currently our rules do not have ADV EMT so the provider needs to follow the rules at the intermediate level. Staff recommends approval.

Moores Hill Sparta Township

Bright VFD/EMS

Walkerton-Lincoln

Culver EMS

Southern Ripley County

A motion was made by Commissioner Zartman to approve the waiver request for the listed provider organizations. The motion was seconded by Commissioner Hamilton. The motion passed.

The following requested a waiver of 836 IAC 2-7.2-3 Emergency medical technician-intermediate provider organization operating procedures Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20 Affected: IC 16-31-3 (B) Endotracheal intubation devices, including the following: (i) Laryngoscope with extra batteries and bulbs. (ii) Laryngoscope blades (adult and pediatric, curved and straight). (iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter. (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate. (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa) albuterol; (bb) ipratropium; (cc) isoetharine; (dd) metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v) Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii) Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate. (xiv) Naloxone. (xv) Nitroglycerin. 836 IAC 2-7.2-1 General requirements for emergency medical technician-intermediate provider organization Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-2 Affected: IC 4-21.5; IC 16-31-3; IC 16-41-10 (f)(2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. Staff recommends: APPROVAL – based on previous Commission action and current rules.

Warren Township

Batesville EMS

Southwest Central

Vincennes City FD

A motion was made by Commissioner Mackey to approve the listed provider organization waiver requests. The motion was seconded by Commissioner Zartman. The motion passed.

The following requested a waiver of 836 IAC 2-2-1(g) 836 IAC 2-2-1 General requirements for paramedic provider organizations (g) Each paramedic provider organization shall do the following: (1) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. Muscatatuck Urban Training Center Fire Department is asking for a waiver of the 24/7 rules for paramedic coverage. They currently have one paramedic and soon to have 3 ADV EMT moving up from basic-advanced. They would like to provide ALS when staffing allows. Staff recommends: APPROVAL – based on previous Commission action and current rules.

Muscatatuck Urban Training Center Fire Department

A motion was made by Commissioner Mackey to approve the waiver request. The motion was seconded by Commissioner Lockard. After some discussion Commissioner Mackey amended his motion to include a 6 month reporting requirement. Commissioner Lockard seconded the amendment. The motion passed.

The following requested a waiver of 836 IAC 2-14-3 Advanced life support nontransport vehicle specifications Authority: IC 16-31-2-7 Affected: IC 16-31-3 Sec. 3 (b) All advanced life support nontransport vehicles shall meet or exceed the following minimum specifications for electrical systems: (3) Each advanced life support nontransport vehicle shall have an audible backup warning device that is activated when the advanced life support nontransport vehicle is shifted into reverse. (c) All advanced life support nontransport vehicles shall meet the following requirements for external identification: (1) Warning lights of red or red and white, at the discretion of the owner, and shall conform with Indiana law. All lights on vehicle shall be in working condition. (2) Each advanced life support nontransport vehicle shall display the four (4) numbers of the commission-assigned advanced life support nontransport vehicle certification number. The four (4) numbers, in sequence, shall be placed on each side of the advanced life support nontransport vehicle on the right and left front fenders and on the rear portion of the vehicle. Each number shall be in block letters not less than three (3) inches in height. These numbers shall be displayed in color contrasting, reflective material. The numbers shall be placed on the vehicle within seven (7) days of the receipt of the advanced life support nontransport vehicle certificate. The numbers shall be removed or permanently covered by the provider organization when the advanced life support nontransport vehicle is permanently removed from service by the provider organization. (3) A commission-certified vehicle sticker shall be displayed on all certified advanced life support nontransport vehicles. Lake County STAR Team is requesting a RENEWAL waiver of the backup alarm, 4 digit certification numbers and the red/White light requirement. This is a police agency and have blue lights on the ALS non-transport vehicle.

Lake County STAR Team

A motion was made by Commissioner Mackey to approve the renewal of this waiver request. The motion was seconded by Commissioner Zartman. The motion passed.

The following requested a waiver of (h) A paramedic ambulance service provider organization must be able to provide a paramedic level response. For the purpose of this subsection, "paramedic response" consists of the following: (1) A paramedic. (2) An emergency medical technician or higher. (3) An ambulance in compliance with the requirements of section 3(e) of this rule. (4) During transport of the patient, the following are the minimum staffing requirements: (A) If paramedic level advanced life support treatment techniques have been initiated or are needed: (i) the ambulance must be staffed by at least a paramedic and an emergency medical technician; and (ii) a paramedic shall be in the patient compartment. (B) If an emergency medical technician-intermediate level advanced life support treatment techniques have been initiated or are needed: (i) the ambulance must be staffed by at least an emergency medical technician-intermediate and an emergency medical technician; and (ii) an emergency medical technician-intermediate shall be in the patient compartment. (C) If advanced life support treatment techniques have not been initiated and are not needed: (i) the ambulance must be staffed by at least an emergency medical technician; and (ii) an emergency medical technician shall be in the patient compartment. Concord Twp FD is requesting a waiver of the staffing rule of having an EMT with a Paramedic on the third out ambulance. We have two fully staffed paramedic ambulances staffed with a minimum of EMT/Paramedic 2417. In the event of a third call the third ALS ambulance may be required to respond initially with only a EMT, Paramedic or a Firefighter. In the rare act of a third call when other two ambulances are busy. We request permission to maintain ALS care with only a driver and Paramedic. Staff recommends: approval – based on previous Commission action and current rules.

Concord Township Fire Department

A motion was made by Commissioner Zartman to approve the waiver request with the requirement that Concord Township FD reports to a District Coordinator how many times they have to use only a driver and paramedic on an ALS truck. The motion was seconded by Commissioner Lockard. The motion passed.

The following requested a waiver of Emergency Rule LSA Document #12-393E Section 49 (e) An advanced emergency medical technicians are prohibited from having in their possession, or maintained on board emergency response vehicles, any advanced life support equipment or supplies that have not been approved in writing by the emergency medical technician-intermediate provider organization medical director. (f) Advanced emergency medical technicians shall: (1) not perform a procedure for which the advanced emergency medical technician has been specifically trained: (A) in the Indiana emergency medical technician basic and the Indiana advanced emergency medical technician curriculums: or (B) that has not been approved by the commission as being within the scope and responsibility of that advanced emergency medical technician; Gibson County Ambulance Service is requesting a waiver to add both End Tidal CO2 monitoring and CPAP to the Advanced EMT scope of practice. Staff Recommend: DENY – based on current curriculum and previous Commission decision of adding no more to ADV EMT curriculum.

Gibson County Ambulance Service

A motion was made by Commissioner Zartman to deny the waiver request. The motion was seconded by Commissioner Hamilton. The motion passed.

The following requested a waiver of 836 IAC 2-2-1(h) A paramedic ambulance service provider organization must be able to provide a paramedic level response. For the purpose of this subsection, "paramedic response" consists of the following: (1) A paramedic. (2) An emergency medical technician or higher. (3) An ambulance in compliance with the requirements of section 3(e) of this rule. (4) During transport of the patient, the following are the minimum staffing requirements: (A) If paramedic level advanced life support treatment techniques have been initiated or are needed: (i) the ambulance must be staffed by at least a paramedic and an emergency medical technician; and (ii) a paramedic shall be in the patient compartment. (B) If an emergency medical technician-intermediate level advanced life support treatment techniques have been initiated or are needed: (i) the ambulance must be staffed by at least an emergency medical technician-intermediate and an emergency medical technician; and (ii) an emergency medical technician-intermediate shall be in the patient compartment. (C) If advanced life support treatment techniques have not been initiated and are not needed: (i) the ambulance must be staffed by at least an emergency medical technician; and (ii) an emergency medical technician shall be in the patient compartment. Northeast Allen County Fire & EMS is requesting a waiver of the EMT requirement on a paramedic response. Staff Recommend: APPOVAL – basic on previous Commission action. Request a 6 month update

Northeast Allen County Fire and EMS

A motion was made by Commissioner Zartman to approve the waiver request. The motion was seconded by Commissioner Hamilton. The motion passed.

Vice Chairman Valentine called for a break at 11:31am

Vice Chairman Valentine called the meeting back to order at 11:49am

OLD BUSINESS

1. Parke and Vermillion County 12 lead study and update
   Ms. Angela Powell reported out on the results from the study. (see attachment #5)
2. Tactical Medical Training
   Director Garvey asked that this topic be tabled until the next meeting.

A motion was made by Director Garvey to table the Tactical Medical Training until the August meeting. The motion was seconded by Commissioner Olinger. The motion passed to table until the August meeting.

NEW BUSINESS

1. Authorization of Administrative Law Judges
   Legal Counsel Mara Snyder stated that Gary Bippus has taken a position outside of the agency. At this time the Agency does not have an in house ALJ. The agency is working on a memorandum of agreement with the Attorney General's Office to provide deputy Attorneys General to serve as Administrative Law Judges for the Commission. The Commission has to authorize them to act on the Commissions behalf.

A motion was made by Commissioner Hamilton to authorize Donna S. Sembroski, Gordon G White, Kevin C McDowell all deputy Attorneys General to serve as Administrative Law Judges for the Commission including without limitation the authority to 1. Assume all pending administrative cases before the Commission 2. Act as administrative law Judge for all new cases to come before the Commission 3. Hear and rule upon petitions for stays of enforcement 4. Hear and decide appeals to emergency orders issued with respect to one or more violations of the Commission's rules or ethical statuses. The motion was seconded by Commissioner Olinger. The motion passed.

2. Blood Glucose monitoring for EMTs
   Mrs. Stephanie Freeman presented a report on diabetes and the importance of monitoring of blood glucose levels. (see attachment #6). Commissioner Olinger suggested Mrs. Freeman go to the IRB for approval of the study. Discussion followed.

A motion was made by Commissioner Zartman for Mrs. Freeman to go to the IRB for approval of the study. Then after receiving approval from the IRB return to the Commission with this request. The motion was seconded by Commissioner Hamilton. The motion passed.

ADMINSTRATIVE PROCEEDINGS

1. Administrative Orders Issued
   a. Personnel Orders
      i. One Year Probation

Order No. 0031-2014 Justin R. Woodall

No action required, none taken

      ii. 2 Year Probations

Order No. 0028-2014 David Lee Archer

No action required, none taken

Order No. 0030-2014 Erica J. Finley

No action required, none taken

Order No. 0029-2014 Wilson Donald Ginder

No action required, none taken

Order No. 0028-2014 Jason E. McCoy

No action required, none taken

iii. **Denial**

Order No. 0033-2014 Stephen Gorrel

No action required, none taken

iv. **Revocation for 1 Year**

Order No. 0032-2014 Allen M. Soppet

No action required, none taken

Order No. 0034-2014 Justin L. Talkington

No action required, none taken

v. **Emergency Order**

Order No. 0035-2014 Jeremy West

No action required, none taken

b. Training Institutions

i. Letter of Reprimand

IU Ball Memorial Hospital

No action required, none taken

2. **Appeals Filed in a timely manner**
   a. Soppet, Allen M.
   b. Talkington, Justin

A motion was made by Commissioner Zartman to grant the appeals for Mr. Allen Soppet and Mr. Justin Talkington. The motion was seconded by Commissioner Olinger. The motion passed.

Commissioner Zartman talked about an email he received from a gentleman that had been taken sactions against in the past. Commissioner Zartman sent it to the rest of the Commission members for them to read. The email is an apology as well as a request to work with the Narcotics sub-group in coming up with a program to help others that are in the same situation. Commissioner Zartman believes the Commission should consider the gentleman's request. Discussion followed. Vice Chairman Valentine directed Chairman of the Narcotics sub-committee Commissioner Zartman to invite the gentleman to work with the Narcotic sub group. Director Garvey stated that the staff has already been in contact with the Indiana Emergency Medical

Services Association regarding peer programs similar to those that nurses use. Legal Counsel Mara Snyder stated that she believes the Commission can draft a proposal that will allow the program to become part of the sanctioning process with in the current statutes.

STAFF REPORTS

A. Data Registry (see attachment #7)

Director Garvey announced Mr Gary Robison's retirement from the agency and that we will be posting Gary's position to keep the program moving. Director Garvey also reported that Indiana is still reporting to NEMSIS. Some discussion followed.

Vice Chairman Valentine directed staff to include data registry in the rule rewrites.

B. Field Staff Report

Ms. Robin Stump reported the completion of the EMS forums around the state and had approximately 200 personnel in attendance at those forums. (see attachment #6).

C. Certifications report (see attachment #8)

D. Training Report (see attachment #9)

Mrs. Elizabeth Westfall reported out on the National Registry statistics. Mrs. Westfall reported that there are 23 ALS accredited programs in that state. There are 21 Advance courses in progress as of today. Mrs. Westfall announced that as of July 7th written test taken at Ivy Tech will be through the Acadis system. This means that Reports of Training will need to be turned in before students can take the written test. PI updates are still continuing to date there have been 400 Primary Instructors attend the updates. The final PI update will take place on June 26th at Wayne Township. Commissioner Zartman asked how the Primary Instructors will be notified regarding change with the testing procedure. Mrs. Westfall stated that an email will be sent to all of the Primary Instructors and the change will be posted on the website. Director Garvey stated that the final PI update will be recorded and kept on file. Discussion followed regarding what will happen if the primary instructors do not attend any of the updates. Legal Counsel Mara Snyder stated that when something is required it needs to have the rule sited that it connected with that rule. Staff was directed to add the rule citation of Section (e)(3). The rule citation of Section (e)(3) needs to be added to the information regarding the POST training as well as adding the deadline date of December 31, 2014 for taking the POST training and test. The Commission will revisit the discussion regarding Primary Instructors that have not attended the PI updates at the August 20th meeting.

STATE EMS DIRECTOR'S REPORT

Director Garvey announced that the next Commission meeting will be held on Wednesday August 20th at 3pm at Keystone at the crossing Sheraton Hotel in conjunction with Indiana Emergency Responder Conference. Director Garvey also announced that there will be a memorial service for all of the Emergency Responders that have passed away through this last year. Director Garvey asked that anyone that has names, a short bio, and picture for inclusion in the memorial send the information into the office. Director Garvey announced there are 3 vacancys within the Training section and also that renovations have cause longer than normal delays in processing certification. Director Garvey thanked Methodist staff for hosting the Commission meeting as well as thanking District One Task Force for the display out in the parking lot. Direct Garvey asked Emery Garwick to talk about the significance of the room. Mr. Garwick stated that the

very first Paramedic program class for the state of Indiana was held in this classroom in 1974. Director Garvey also noted that there has been progress made in the work on the state strategic plan for EMS and introduced Beau Parker and Kelly Russ and recognized them for their work on the strategic plan to date.

CHAIRMAN'S REPORT AND DIRECTION

Vice Chairman Valentine reviewed assignments from this meeting. The TAC has nothing new assigned and was instructed to keep working on their current projects. The staff was assigned to write the draft for the teleconferencing for the TAC and the Commission. The staff is to also look at the AEMT continuing education and Data to move to the version 3 NEMSIS. Staff is also directed to follow up on the PI and Post to site the rules on the website.

ADJOURNMENT

A motion was made by Commissioner Zartman to adjourn the meeting. The motion was seconded by Commissioner Hamilton. The motion passed. The meeting was adjourned at 1:51p.m.

Approved Charles Valentine

Charles Valentine, Vice Chairman

Attachment #1

Indiana Trauma Registry Pre-hospital Data Report Report for June 2014

This report from the Indiana State Department of Health (ISDH) Indiana Trauma Registry Pre-hospital data includes 145,547 runs from 112 pre-hospital providers during the time frame from June 1, 2013 through May 27, 2014. This report also focuses on several sub-populations in this time frame:

1. 30,624 chest pain incidents where chest pain was the complaint reported by dispatch or the provider's primary or secondary impression was chest pain/ discomfort.
2. 11,748 incidents where the 12-lead ECG procedure was performed.

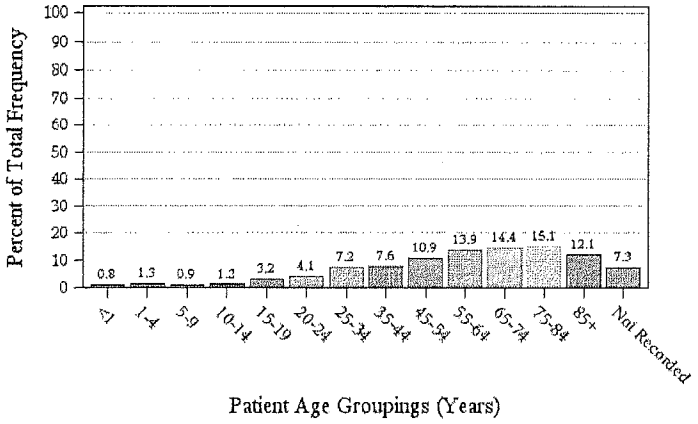
Lastly, 18,228 hospital incidents were reported to the ISDH Indiana Trauma Registry from the same time period (June 1, 2013 to May 27, 2014) and were included to provide data on the injury severity score (ISS) by public health preparedness district.

At a previous EMS Commission meeting, it was requested that prior aid data be provided, specifically to know if aspirin (ASA) was given before the EMS arrived on the scene in cases of chest pain. Additionally, it was requested that medical history of aspirin allergy be provided for incidents of chest pain. Approximately 0.49% of chest pain cases were reported to have allergies to aspirin (15 cases). Please note that the medication allergies data element is a National Emergency Medical Services Information System (NEMSIS) gold element which is not required by either the Indiana Department of Homeland Security (IDHS) or ISDH Pre-hospital registries.

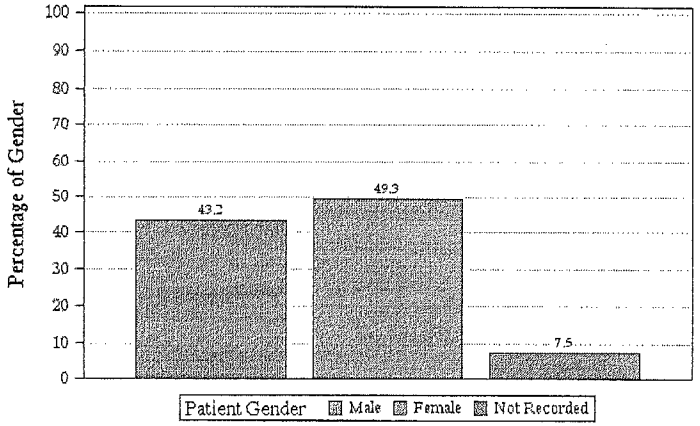
Indiana State
Department of Health

Indiana Trauma Registry Pre-Hospital Data Report
06/01/2013-05/27/2014
100 Total Providers Reporting 145,547 Incidents

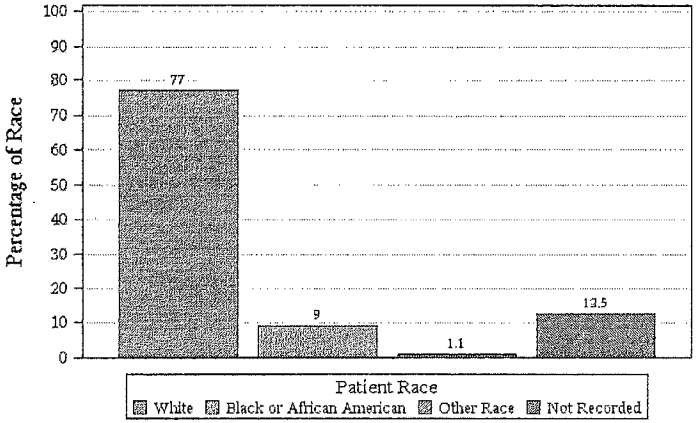
Patient Age (Years)



Patient Gender

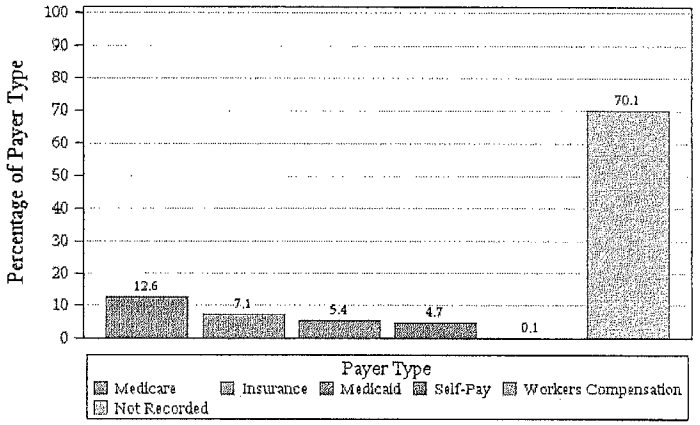


Patient Race



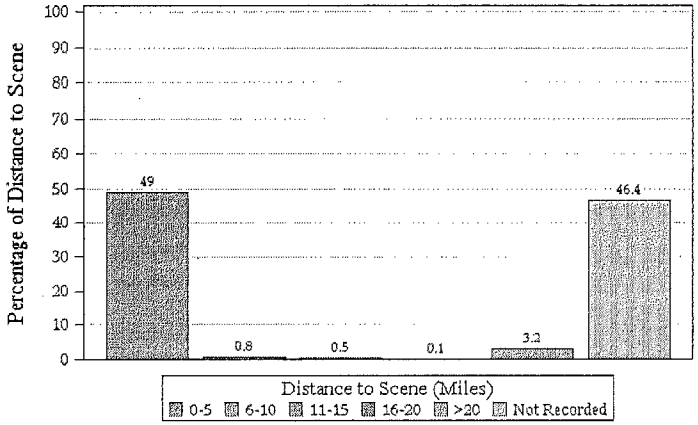
<1% Race: Asian, Native Hawaiian, American Indian/Alaskan Native

Payer Type

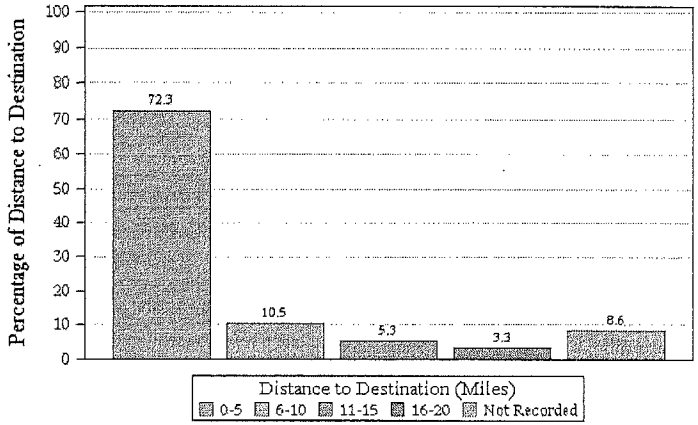


Indiana Trauma Registry Pre-Hospital Data Report
06/01/2013-05/27/2014
100 Total Providers Reporting 145,547 Incidents

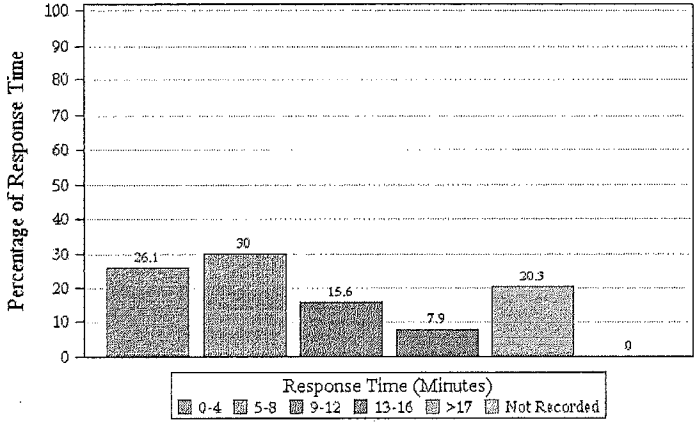
Distance to Scene (Miles)



Distance to Destination (Miles)

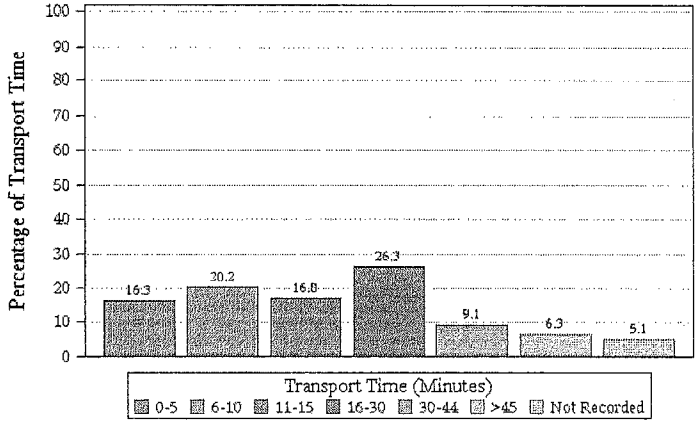


Response Time (Minutes)



Response Time: Difference in Time from Dispatch to Arrival on Scene

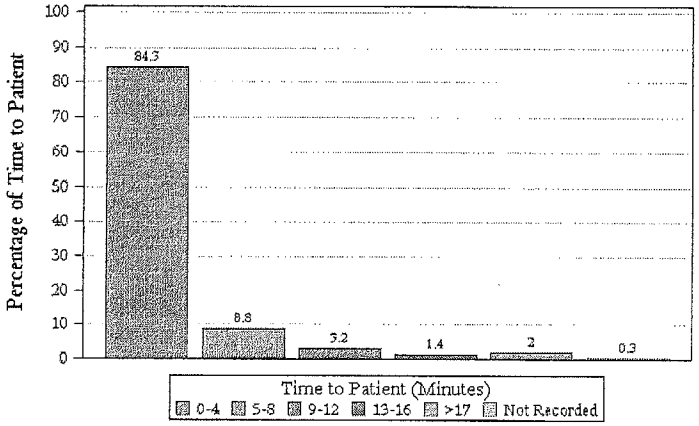
Transport Time (Minutes)



Transport Time: Difference in Time from Departure from Scene to Arrival At Destination

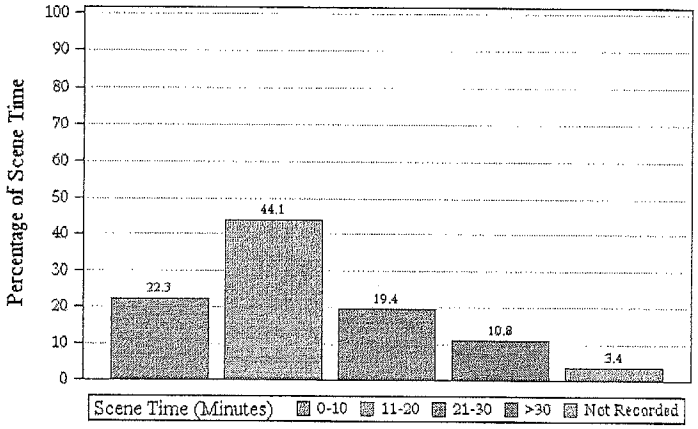
Indiana Trauma Registry Pre-Hospital Data Report
06/01/2013-05/27/2014
100 Total Providers Reporting 145,547 Incidents

Time to Patient (Minutes)



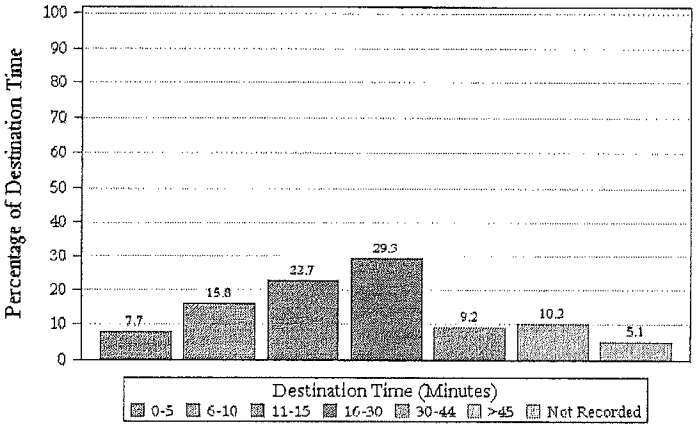
Time To Patient: Difference in Time from Arrival at Scene

Scene Time (Minutes)



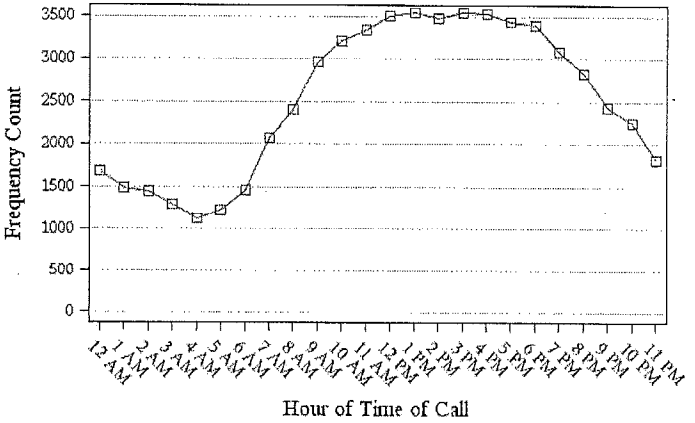
Scene Time: Difference in Time from Arrival at Scene

Destination Time (Minutes)



Scene Time: Difference in Time from Arrival at Destination to Unit Back in Service

Time of Call



Time of Call Not Recorded for 85,064 Incidents

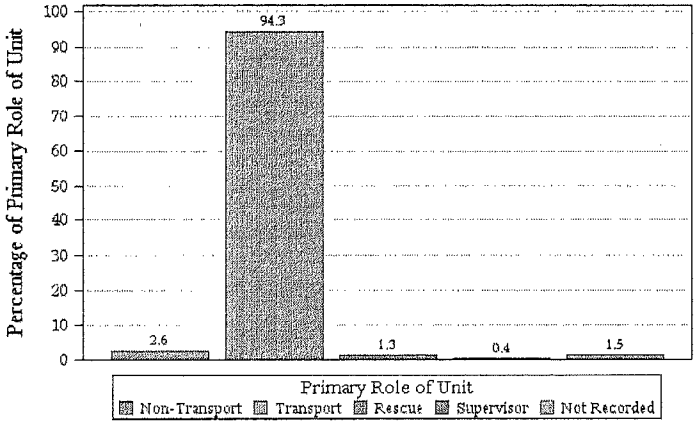
Average Run Mileage

Obs	Destination	Miles
1	Mileage to Scene	3.0
2	Mileage to Destination	3.4
3	Total Mileage	7.4

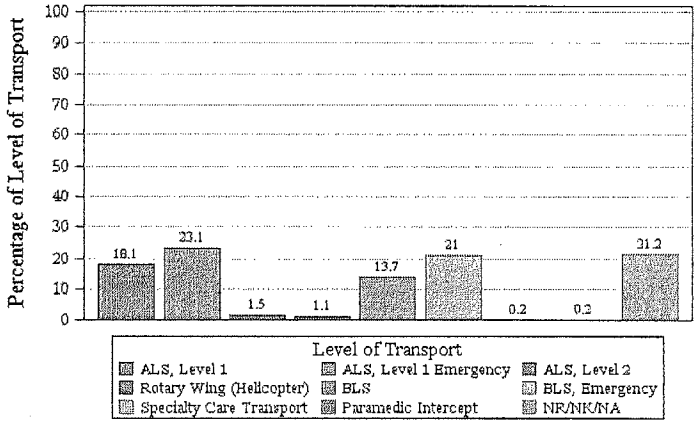
Average Run Time

Obs	Destination	Minutes
1	Time to Scene	12.28
2	Time to Patient	2.86
3	Time at Scene	18.45
4	Time to Destination	18.35
5	Back in Service	22.20
6	Total Run Time	63.75

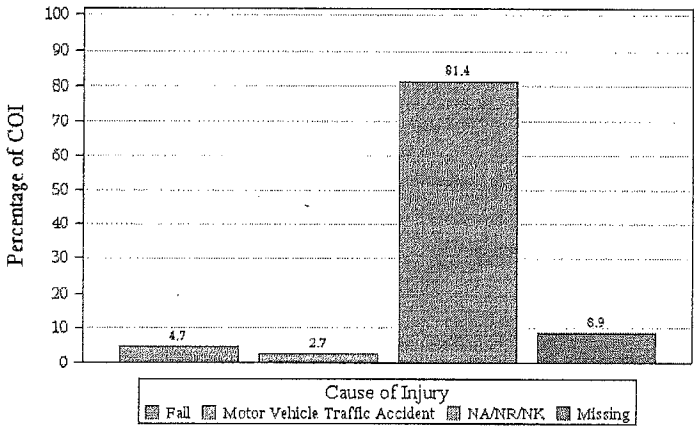
Primary Role of Unit



Level of Transport

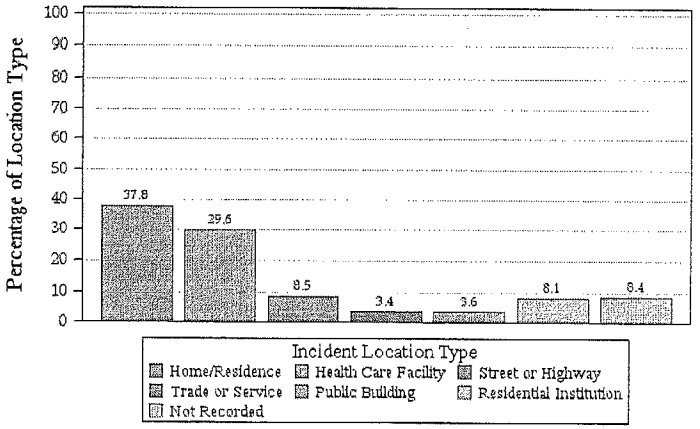


Cause of Injury (COI)



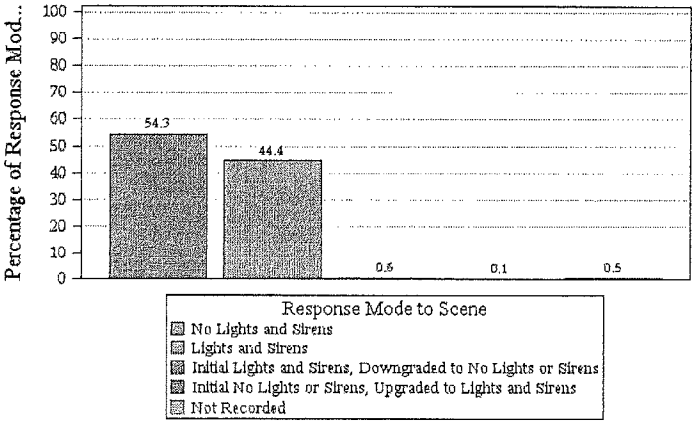
Causes of Injury <1.5% not listed (40 variables)

Incident Location Type

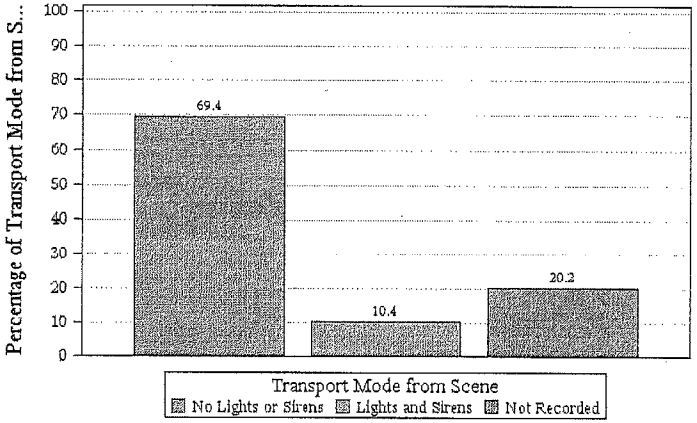


Incident Location Type <1% not listed (4 variables)

Response Mode to Scene

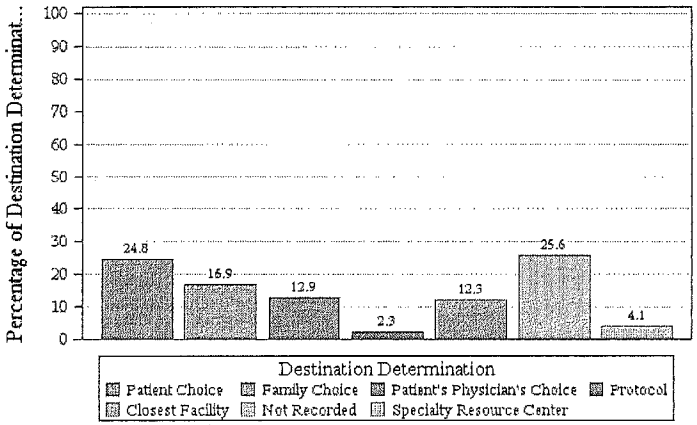


Transport Mode from Scene



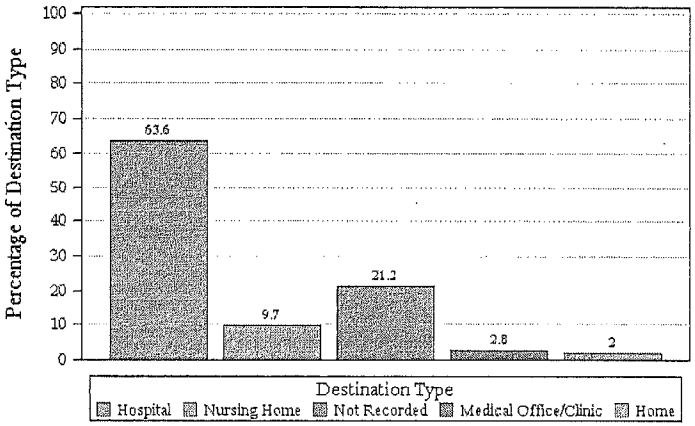
Indiana Trauma Registry Pre-Hospital Data Report
06/01/2013-05/27/2014
100 Total Providers Reporting 145,547 Incidents

Destination Determination



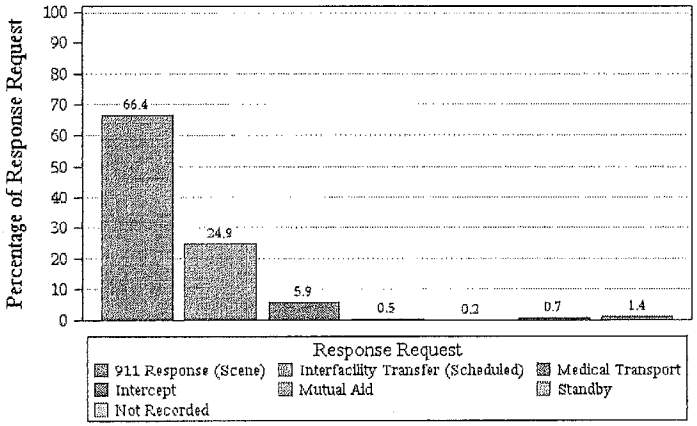
Destination Determinations <1% Not Listed (5 Variables)

Destination Type

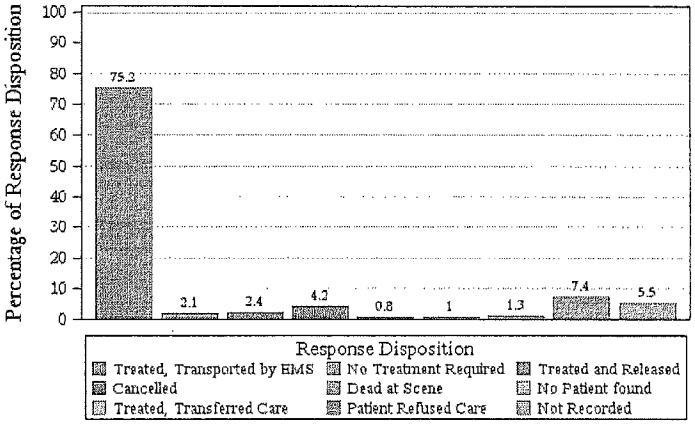


<1% Destination Type:EMS Responder (Ground),Other Morgue, Other EMS Responder (Air), Police/Jail

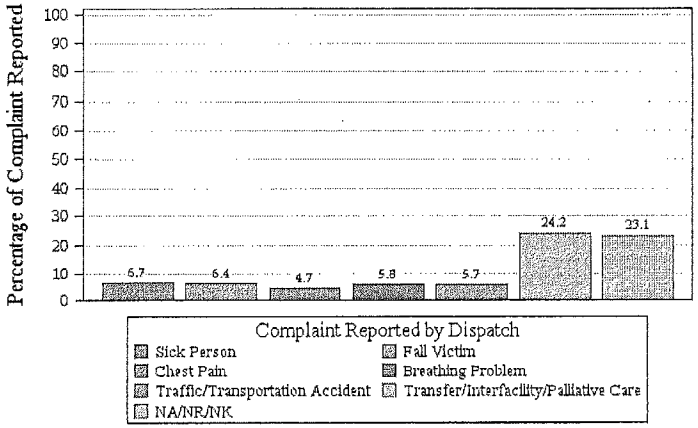
Response Request



Response Disposition

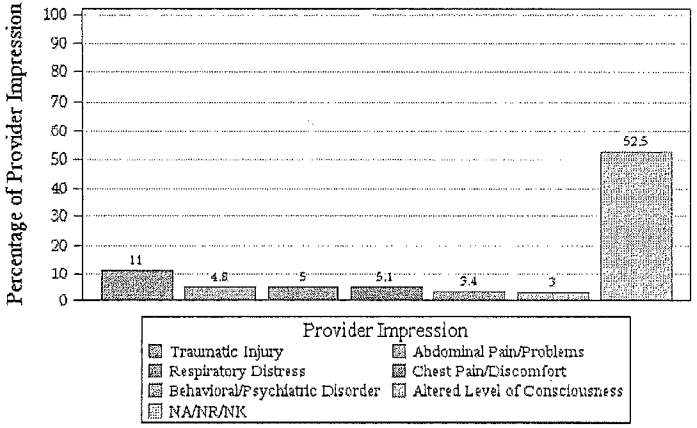


Complaint Reported by Dispatch



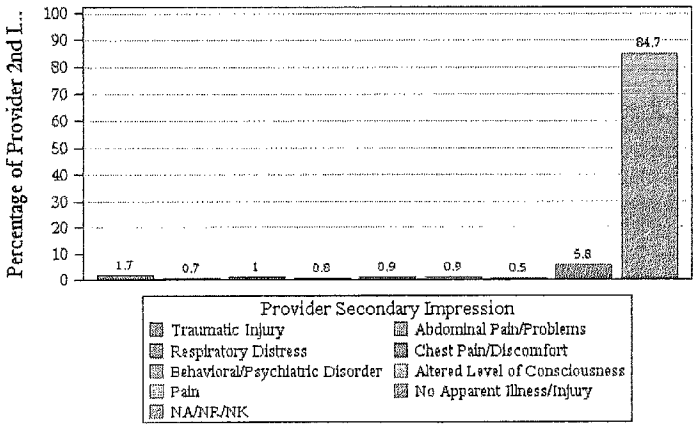
Complaints <2.5% not listed (10 variables)

Provider Primary Impression



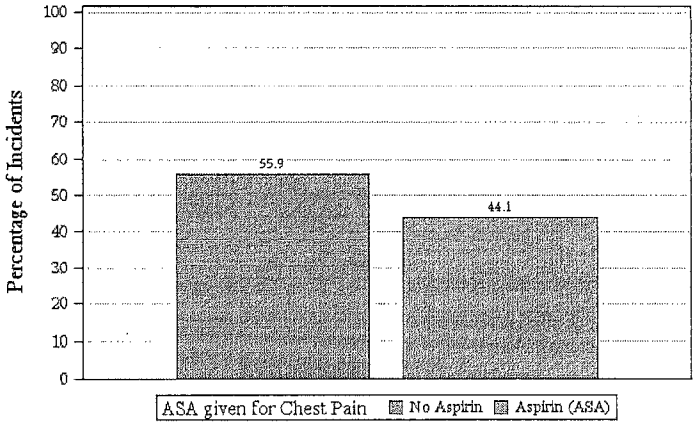
Primary Impressions <2.5% not listed, 26 variables

Provider Secondary Impression



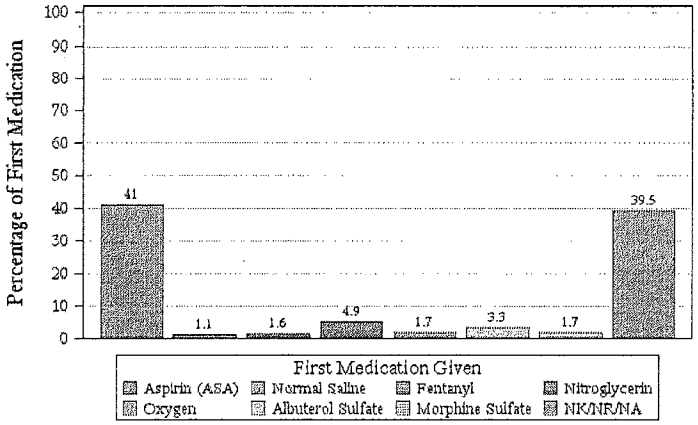
<.5% P.I.:Pain, Seizure, Other. Stroke/CVA,Syncope/Fainting
Poisoning/Drug Ingestion, Cardiac Rhythm Disturbance, Diabetic Symptoms

Chest Pain Incidents where ASA Given



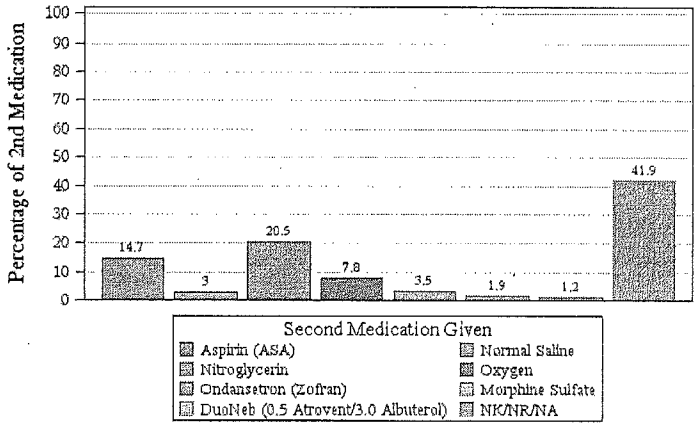
Chest Pain Incidents where ASA was Given (2013-YTD)
Chest Pain as complaint reported by dispatch or
the provider's primary or secondary impression; N= 30,624

First Medication Given for Chest Pain



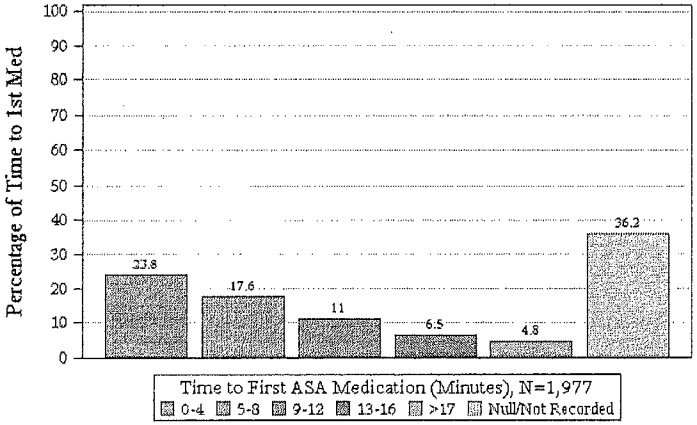
First Medications <0.5% not listed (39 variables)

Second Medication Given for Chest Pain



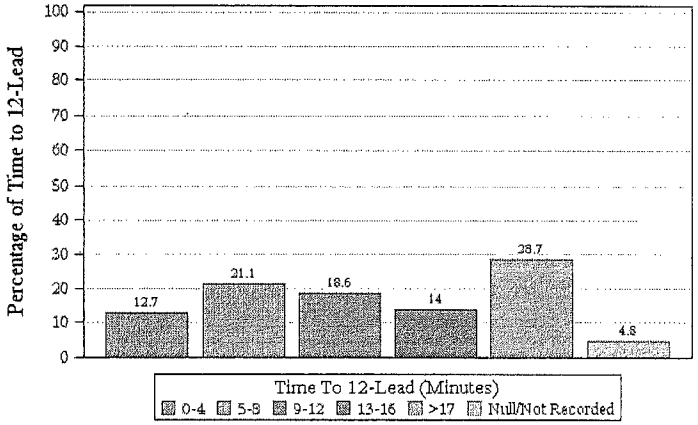
Second Medications <1% not listed (51 variables)

Time to First ASA Medication (Minutes)



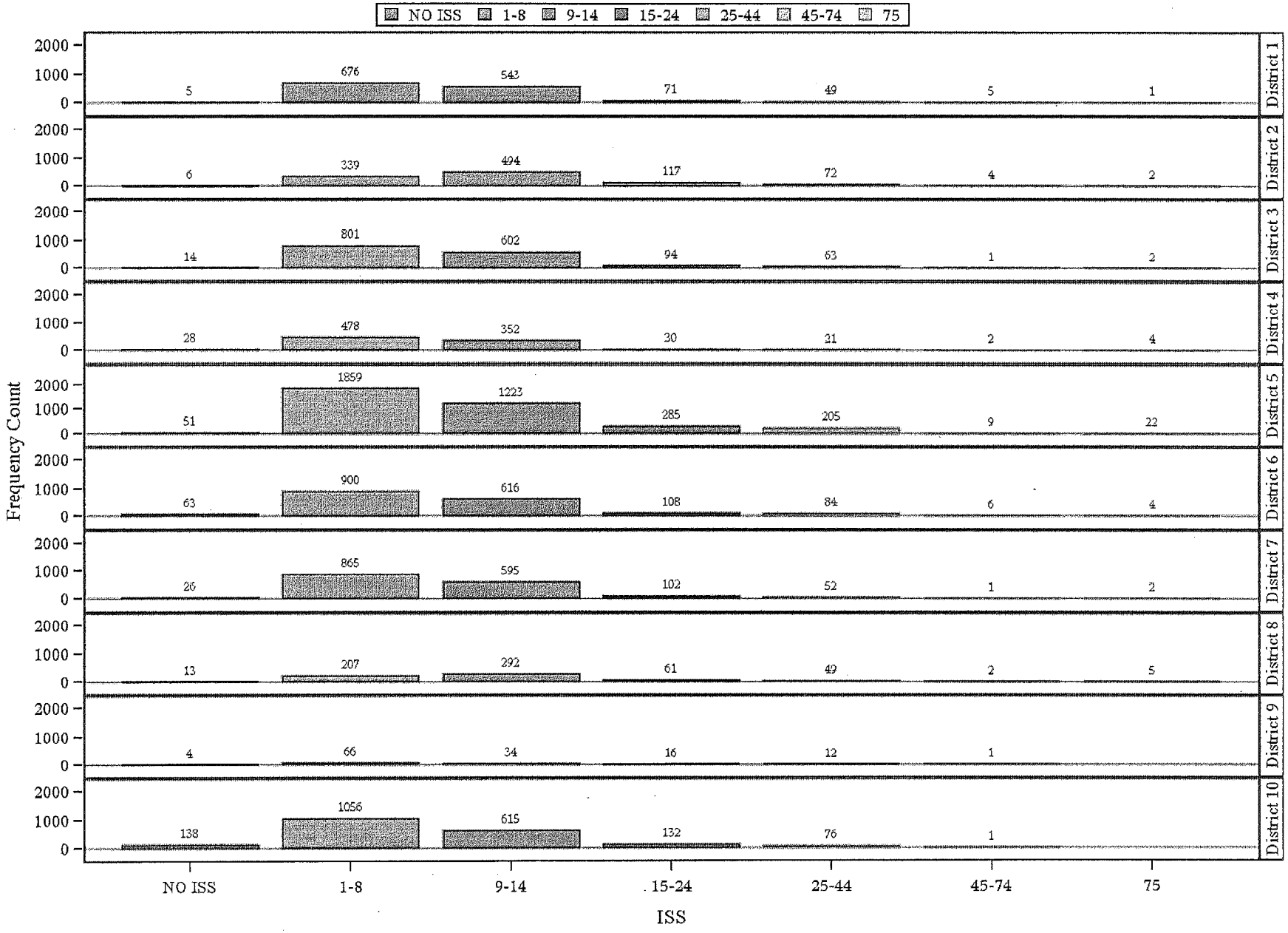
Time to 1st Med: Time from Arrived at Patient to First Medication (Aspirin[ASA]) Administered for Chest Pain

Time to 12-Lead (Minutes)



Time to 12-Lead: Time from Arrived at Patient to Time 12 lead ECG Procedure Performed; N=11,748

Indiana Trauma Registry- June 1, 2013 to May 27, 2014 - 18,228 Incidents
Injury Severity Score By Public Health Preparedness Districts



Attachment #2

MICHAEL R. PENCE, Governor
STATE OF INDIANA

INDIANA DEPARTMENT OF HOMELAND SECURITY
302 West Washington Street
Indianapolis, IN 46204

EMERGENCY MEDICAL SERVICES COMMISSION

TECHNICAL ADVISORY COMMITTEE MEETING MINUTES

DATE:	June 4, 2013; 10:00 a.m.
LOCATION:	Noblesville Fire Department, Station 77 15251 Olio Road Noblesville, IN 46060
PRESENT:	Leon Bell, Chairman, ALS Training Institute Tina Butt, First Responder Training Director Sherry Fetters, Vice Chairman, EMS Chief Executive Officer Jessica Lawley, ALS Training Program Director Michael Gamble, Emergency Department Director Michael McNutt, BLS Training Program Director Sara Brown, EMS Medical Director Edward Bartkus, EMS Medical Director Jaren Kilian
NOT PRESENT:	Charles Ford, EMS Chief Executive Officer Faril Ward, EMS Chief Operating Officer Elizabeth Weinstein, EMS for Children
OTHERS PRESENT:	Myron Mackey, EMS Commissioner

John Zartman, EMS Commissioner

Elizabeth Fiato, IDHS Staff

Mike Garvey, IDHS Chief of Staff

Other IDHS Staff and members of the EMS Community

1) Meeting called to order at 10:07 a.m. by Chairman Bell.

2) Roll call, quorum present

3) Adoption of minutes:
Chairman Bell called for a motion to accept the minutes from the April 2nd meeting.
A motion was made by Vice Chairwoman Fetters to accept the minutes. The motion was seconded by Jessica Lawley.
Jessica Lawley stated that Mr. Gamble should be Dr. Gamble on pages 7 and 8. Vice Chairwoman Fetters stated that her last name was spelled incorrectly throughout the meetings. Jaren Kilian was missed in the attendance.
A motion was made by Vice Chairwoman Fetters to accept the minutes as amended. The motion was seconded by Dr. Gamble. The motion passed.

4) Announcements:
Chairman Bell read the dates for the TAC meetings for the next fiscal year. The meetings will be held at Noblesville FD Station #77 at 10:00am. The dates are as follows:
   a. July 9, 2013
   b. September 10, 2013
   c. November 12, 2013
   d. January 14, 2014
   e. March 11, 2014
   f. May 13, 2014

Commission Report:

Mrs. Elizabeth Fiato reported out on events that have taken place within the IDHS offices as well as the EMS Education Working Group.

Mrs. Fiato stated that Mr. Rick Archer tenured his resignation after being offered a job in the private sector. Mr. Archer's position has

been posted and since closed. At this time Mrs. Fiato has not received an update as to a status of the hiring process. Mrs. Fiato also mentioned that IDHS has hired a consulting firm to figure out the status of our agency. She further states that some changes might occur within the agency and could be announced at the August EMS Commission meeting.

In regards to the EMS Education working group we had a successful first meeting. The group came up with an objectives list. Most of the objectives involve IDHS processes. The items that need to involve educational curriculum or the Technical Advisory Committee have been set aside until such a time as a meeting can be set for a public meeting to involve the TAC. Most of the current work is going to be concerning processes within IDHS. The first topic that is being discussed is the State Representatives program. Other topics under discussion by the education working group are testing center process. The priority list has been made some of the items on the list are scenarios for EMT practical testing, Indiana PI rules looking at them and assessing how they can be integrated into the PI exam, the PI exam to be reviewed with the psychometrician (the TAC members will be invited to this meeting just not the general public to protect the integrity of the exam), quality assurance committee discussion about resurrecting this committee- the committee was used to look over exam procedures, exam scores, and other items that came into IDHS when it was in existence. These items have been set aside: SMART triage, POST, Indiana driving, reciprocity, SIDS, Autism, Hazmat, extrication, and an approved book list. The group will meet again on June 20th venue to be announced. This group is not taking over anybody or any other group this group is to supplement the IDHS staff.

Chairman Bell commended the staff on the weekly news letter that is being sent out.

5) Old Business
    1) PI recommendations- Vice Chairwoman Fetters
        Ms. Fetters turned the floor over to Ms. Jessica Lawley since the education group took over the PI recommendations.

Ms. Lawley reported that a draft PI application has been sent to Mrs. Liz Fiato and Ms. Candice Hilton at IDHS and both seemed content with the application. Discussion was had regarding educational requirements for individuals that have not taken the Indiana PI course. The following is a summary of the report that Ms. Lawley presented:

PI process

Define "1 year" in IAC 836-agreed on at April meeting

- Application-consensus from sub-committee
- Process
  - Complete
    - EMT written before class
    - EMT practical prior to teaching the internship
    - PI exam prior to teaching the internship
- PI course needs to be added to the BLS training application both initial and renewal
- 1 year from course completion

A three hour discussion followed Ms. Lawley's report. A break was taken during the discussion from 11:09am- 11: 19am. The following topics where discussed during the three hours:

- Alternate ways to show competence other than exams
- Make Training Institutions responsible for validation of knowledge
- Responsibility for liability (who's responsible)
- Possible collaboration between Training Institutions to widen PI candidates knowledge base before they teach on their own without mentor.
- Certified PI has to be present while PI candidate is teaching during internship
- Does candidate have to teach every module or just some of them during internship
- Cut scores for exams- who determines what they are?
- Defining the 1 year time frame-when does it start

A motion was made by Mr. Jaren Kilian to make the course completion date the start of the 1 year time frame in which the internship and exams have to be completed. The motion was seconded by Ms. Tina Butt. The motion passed unanimously.

More discussion followed the motion regarding the above mentioned topics and in addition to the above topics affiliation and when a PI candidate should get affiliated with a Training Institution.

A motion was made by Mr. Jaren Kilian to accept the following recommendation as agreed upon after the three hour discussion concerning the PI recommendations:

1. **A PI candidate must successfully complete the PI certification exam and internship within 1 year of the PI course completion date.**
2. **A PI application will be submitted with the course completion report of training.**
3. **The course completion date will serve as the application date for the PI candidate.**
4. **Affiliation begins when the Primary Instructor Program Training Instruction Approval Form (PI Internship Affiliation as listed on the IDHS website) is complete.**
5. **If the PI candidate is requesting reciprocity, the candidate must successfully complete the exam and internship within 1 year from the time he/she submits the PI application.**

The motion was seconded by Dr. Edward Bartkus. The motion passed unanimously.

Chairman Bell reassigned writing a policy statement and working on forms for PI candidates to the education sub-committee.

Chairman Bell called for a break at 12:54pm-1:00pm
1:00pm broke into sub-committee's for group work.
1:31pm reconvened at for sub-committee reports
Chairman Bell stated that at the July TAC meeting he plans to work through the assignments from the EMS Commission meeting and sub-committee work.

6) Good of the order

Hearing nothing else for the good of the order Chairman Bell called for a motion to adjourn.

A motion was made my Vice Chairwoman Fetters to adjourn the meeting. The motion was seconded by Mr. Jaren Kilian. The motion passed. The meeting was adjourned at 1:35pm.

Approved _____

Leon Bell, Chairman

TECHNICAL ADVISORY COMMITTEE – TASK SUMMARY

INDIANA STATE E.M.S. COMMISSION

TASK INFORMATION

Date Assigned:

Assigned to: **TAC Chairman – Mr. Bell**

Job Task: **Drafting continuing education requirements for renewal of the IDHS Advanced EMT certification.**

Commission Staff:

Review Period:

ASSIGNMENT REVIEW - GUIDELINES - GOALS

TAC was assigned to draft continuing education requirements for renewal of the IDHS Advanced EMT certification.

TAC RECOMMENDATION

The TAC Education Sub-committee drafted continuing education requirements for renewal of the IDHS Advanced EMT certification, and said policy was approved by the TAC on March 4, 2014.

The TAC makes the following recommendations:

1. Please see the attached form

LIMITATIONS – CHALLENGES – FISCAL IMPACT

The TAC does not believe there is a fiscal impact. The TAC does not believe there will be any expected limitations or challenges.

FORMAL MOTION

TAC makes a motion that:

1. The EMS Commission to approve the continuing education requirements for renewal of the IDHS Advanced EMT certification.

ADDITIONAL COMMENTS

Please see the attached document/

VERIFICATION OF REVIEW AND SUBMISSION

By signing this document, the (TAC) Technical Advisory Committee formally submits to the Indiana State EMS

Commission the above proposed recommendations for review, consideration, and implementation. We acknowledge receipt of review, and submit this document for consideration to the Indiana EMS Commission on the date listed below.

Chairman, TAC Committee	*Date*
Vice-Chairman, TAC Committee	*Date*

EMS COMMISSION – RECOMMENDATION - ACTION

Commission Actions: **Date:**

- ☐ Approved, as listed.
- ☐ Approved, with changes listed below.
- ☐ Re-assigned for future recommendation.
- ☐ Rejected
- ☐ Other

COMMENTS:

Continuing Education Hours for Certification Renewal

The following charts depict a comparison of all levels with both current didactic requirements and newly proposed didactic requirements.

Current requirements:

<table>
<tr><th>Topic</th><th>EMR- 16 hours (12 NR)</th><th>EMT- 40 hours (24 NR)</th><th>AEMT</th><th>Paramedic-72 hours (72 NR)</th></tr>
<tr><td>Preparatory</td><td rowspan="5">4 hours in "defibrillation and airway management"</td><td rowspan="12">34 hours "of any combination of lectures, critiques, skills proficiency exams, continuing education or teaching sessions consistent with the EMT–Basic curricula."</td><td rowspan="15">Specific continuing education requirements for this level have not yet been established</td><td>X (not required at this level)</td></tr>
<tr><td>Airway</td><td>X (not required at this level)</td></tr>
<tr><td>Airway, Breathing, Cardiology</td><td>16</td></tr>
<tr><td>Patient Assessment</td><td>X (not required at this level)</td></tr>
<tr><td>Circulation</td><td>X (not required at this level)</td></tr>
<tr><td>Illness/injury</td><td rowspan="10">16 hours "of any combination of lectures, critiques, skills proficiency examination, or audit and review, which reviews subject matter presented within the approved EMR curriculum."</td><td>X (not required at this level)</td></tr>
<tr><td>Childbirth/children</td><td>X (not required at this level)</td></tr>
<tr><td>Medical</td><td>8</td></tr>
<tr><td>Medical/behavioral</td><td>X (not required at this level)</td></tr>
<tr><td>OB/pediatrics</td><td>16</td></tr>
<tr><td>Trauma</td><td>6</td></tr>
<tr><td>Operations</td><td>2</td></tr>
<tr><td>Audit and Review</td><td>6 (if affiliated)</td><td>12</td></tr>
<tr><td>Elective</td><td>6 (only if not affiliated)</td><td>12</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Total:</td><td>20</td><td>40</td><td>72</td></tr>
</table>

Technical Advisory Committee for the EMS Commission

Revision of Continuing Education Didactic Requirements

Education Sub-Committee of TAC

Proposed requirements (please note no change to Paramedic requirements):

Topic	EMR- 16 hours (12 NR)	EMT- 40 hours (24 NR)	AEMT	Paramedic-72 hours (72 NR)
Based upon National Registry Core Requirements				
Preparatory	1	1	X (not required at this level)	X (not required at this level)
Airway	2	2	X	X (not required at this level)
Airway, Breathing, Cardiology	X (not required at this level)	X (not required at this level)	12	16
Patient Assessment	2	3	X (not required at this level)	X (not required at this level)
Circulation	3	X (not required at this level)	X (not required at this level)	X (not required at this level)
Illness/injury	3	X (not required at this level)	X (not required at this level)	X (not required at this level)
Childbirth/children	1	2	X (not required at this level)	X (not required at this level)
Medical	X (not required at this level)	X (not required at this level)	6	8
Medical/behavioral	X (not required at this level)	4	X (not required at this level)	X (not required at this level)
OB/pediatrics	X (not required at this level)	X (not required at this level)	12	16
Trauma	X (not required at this level)	4	5	6
Operational tasks	X (not required at this level)	X (not required at this level)	1	2
Audit and Review	x	6	12	12
Pharmacology	x	x	2	X
Flexible Elective Content				
Elective	4	18 (24 total hours if not affiliated)	22* (These hours shall pertain to the EMT and/or AEMT curriculum *	12
Recommendations for electives: HIPPA, Bloodborne pathogens, OSHA 1910, evidenced-based research trends, specialty care, or based on local need				
Total:	16	40	72	72

Technical Advisory Committee for the EMS Commission

Revision of Continuing Education Didactic Requirements

Education Sub-Committee of TAC

Skill competencies	EMT	AEMT	Paramedic
Cardiac Arrest Management/AED	X	x	x
Airway Management (Oropharyngeal airway, nasopharyngeal airway, bag valve mask, combit-tube, ventilation, mouth to mask with oxygen)	X	x	x
Spinal immobilization, seated	X	x	
Spinal immobilization, supine	X	x	
Patient assessment/management, Trauma	X	X	X
Patient assessment/management, Medical	X	x	X
Long bone immobilization	X		
Joint injury	X		
Traction Splint immobilization	X		
Bleeding and Shock management	x	x	X
Medication Administration, IV, IO		x	X
Obstetrics and gynecological		x	X
Communication and documentation		x	x
12-lead acquisition and transmission		x	
Static and dynamic cardiology of the five (5) AEMT approved rhythms		x	

Attachment #3

Rule 15. Requirements and Standards for Advanced Emergency Medical Technician Provider Organizations

836 IAC 2-7.2-1 General requirements for Advanced Emergency Medical Technician provider organizations

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20
Affected: IC 4-21.5; IC 16-31-3; IC 16-41-10

Sec. 1. (a) A person shall not:
(1) furnish;
(2) operate;
(3) maintain;
(4) advertise; or
(5) otherwise engage in providing;
emergency medical services as an Advanced Emergency Medical Technician provider organization unless the person is certified as an Advanced Emergency Medical Technician provider organization.

(b) If the Advanced Emergency Medical Technician provider organization also provides transportation of emergency patients, the Advanced Emergency Medical Technician provider organization shall be certified as an ambulance service provider organization in accordance with the requirements specified in 836 IAC 1 under IC 16-3.

(c) The Advanced Emergency Medical Technician nontransport provider organizations shall meet the requirements specified in 836 IAC 1-1-4 through 836 IAC 1-1-8.

(d) The Advanced Emergency Medical Technician provider organization shall ensure the following:

(1) Ambulances used are certified and meet the requirements specified in 836 IAC 1-3.

(2) All nontransport emergency medical services vehicles used for the provision of advanced life support meet all of the requirements in 836 IAC 2-14.

(e) The chief executive officer of each Advanced Emergency Medical Technician provider organization shall certify that the provider organization has an agreement, or interdepartmental memo if hospital based, with one (1) or more supervising hospitals for the following services:

(1) Continuing education.

(2) Audit and review.

(3) Medical control and direction.

(4) Provisions to allow the Advanced Emergency Medical Technicians affiliated with the supervised Advanced Emergency Medical Technician provider organization to function within the appropriate hospital department in order to obtain continuing practice in their clinical skills. The agreement or interdepartmental memo shall include a detailed description of how such services shall be provided to the Advanced Emergency Medical Technician provider organization. In those cases where more than one (1) hospital enters into an agreement, or seeks to enter into an agreement, with an Advanced Emergency Medical Technician provider organization as a supervising hospital, the interhospital agreement shall clearly define the specific duties and responsibilities of each hospital to ensure medical and administrative accountability of system operation.

(f) The Advanced Emergency Medical Technician provider organization shall have a medical director provided by the Advanced Emergency Medical Technician provider organization or jointly with the supervising hospital. The medical director is responsible for providing competent medical direction as established by the medical control committee. Upon establishment of a medical control policy, the medical director and chief executive officer of the Advanced Emergency Medical Technician provider organization have the duty to enact the policy within the Advanced Emergency Medical Technician provider organization and accordingly enforce the policy. The duties and responsibilities of the medical director include, but are not limited to, the following:

(1) Provide liaison with physicians and the medical community.

(2) Assure that the:

(A) drugs;
(B) medications;
(C) supplies; and
(D) equipment;

are available to the Advanced Emergency Medical Technician provider organization.

(3) Monitor and evaluate day-to-day medical operations of Advanced Emergency Medical Technician provider organizations.

(4) Assist in the provision and coordination of continuing education.

(5) Provide individual consultation to Advanced Emergency Medical Technicians.

(6) Participate in at least quarterly audit and review of cases treated by Advanced Emergency Medical Technicians of the supervising hospital.

(7) Attest to the competency of Advanced Emergency Medical Technicians affiliated with the Advanced Emergency Medical Technician provider organization to perform skills required of an Advanced Emergency Medical Technician under 836 IAC 4-7.1.

(8) Establish protocols for basic life support and advanced life support.

(9) Establish and publish a list of medications, including minimum quantities and dosages to be carried on the vehicle.

(10) Provide liaison between the:

(A) emergency medical service provider organization;

(B) emergency medical service personnel; and

(C) hospital;

in regards to communicable disease testing under IC 16-41-10.

(g) The Advanced Emergency Medical Technician provider organization shall do the following:

(1) The Advanced Emergency Medical Technician provider organization shall maintain a communications system that shall be available twenty-four (24) hours a day between the Advanced Emergency Medical Technician provider organization and the emergency department, or equivalent, of the supervising hospital using radio or cellular voice communications. The communications system shall be licensed by the Federal Communications Commission.

(2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services.

(3) Notify the commission in writing within thirty (30) days of assigning any individual to perform the duties and responsibilities required of an Advanced Emergency Medical Technician. This notification shall be signed by the provider organization and medical director of the provider organization.

(h) An Advanced Emergency Medical Technician ambulance service provider organization must be able to provide an Advanced Emergency Medical Technician level response. For the purpose of this subsection, "Advanced Emergency Medical response" consists of the following:

(1) An Advanced Emergency Medical Technician.

(2) An emergency medical technician or higher.

(3) An ambulance in compliance with the requirements of section 3(d)(2) of this rule.

(4) During transport of the patient, the following are the minimum staffing requirements:

(i) If Advanced Emergency Medical Technician level advanced life support treatment techniques have been initiated or are needed:

(1) the ambulance must be staffed by at least an Advanced Emergency Medical Technician and an emergency medical technician; and

(2) an Advanced Emergency Medical Technician shall be in the patient compartment.

(j) If advanced life support treatment techniques have not been initiated and are not needed:

(1) the ambulance must be staffed by at least an emergency medical technician; and

(2) an emergency medical technician shall be in the patient compartment.

(k) For an Advanced Emergency Medical Technician provider organization, when an advanced life support nontransport vehicle is dispatched Advanced Emergency Medical Technician response, it shall, at a minimum, be staffed by an Advanced Emergency Medical Technician.

(1) The Advanced Emergency Medical Technician provider organization shall do the following:

(a) Notify the agency in writing within thirty (30) days of any change in the operation as stated in the application.

(2) With medical director and chief executive officer approval, allow a graduate or student of an Indiana approved Advanced Emergency Medical Technician course to perform advanced life support under the direction of a preceptor. This person shall be actively pursuing certification as an Indiana certified Advanced Emergency Medical Technician. This provision shall be limited from one (1) year from date of course completion as indicated on course report.

(l) All ambulances and nontransport vehicles used by the Advanced Emergency Medical Technician provider organization shall meet the insurance requirements under 836 IAC 1-3-6. *(Indiana Emergency Medical Services Commission; 836 IAC 2-7.2-1;*
filed Feb 20, 2003, 8:00 a.m.: 26 IR 2353; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3542; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-
836060011FRA; readopted filed Jul 29, 2010, 8:07 a.m.: 20100825-IR-836100267RFA)

836 IAC 2-15-2 Application for certification; renewal

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 2. (a) Application for certification as an Advanced Emergency Medical Technician provider organization shall be made on forms provided by the agency and shall include, but not be limited to, the following:

(1) An applicant shall complete and submit the required forms to the agency at least sixty (60) days before the requested effective date of the certificate.

(2) Each application shall include a narrative summary of plans for providing advanced life support services, including the following:

(A) Defined primary area of response, including location of advanced life support response vehicles.

(B) A listing of all Advanced Emergency Medical Technicians, including certification numbers, to be affiliated by the Advanced Emergency Medical Technician provider organization.

(C) The staffing pattern of personnel.

(D) Base of operations.

(E) Organizational structure, including name, address, and phone numbers for the:

(i) owner;

(ii) chief executive officer;

(iii) chief operations officer;

(iv) training officer; and

(v) medical director.

(F) Location of Advanced Emergency Medical Technician provider organizations records.

(G) Proof of insurance coverage for emergency medical service vehicles as required by 836 IAC 1-3-6.

(H) Plans and methodologies to ensure that the trained personnel are provided with supervised continuing education to maintain proficiency. Continuing education is under the direct supervision of the Advanced Emergency Medical Technician provider organization medical director with the cooperation of the supervising hospital.

(I) A listing of medications and special onboard life support equipment to be carried on board each vehicle as approved by the medical director.

(J) Letter of approval from the supervising hospital stating acceptance of the:

(i) Advanced Emergency Medical Technicians;

(ii) agreement to fulfill the responsibilities of the supervising hospital.

(K) Certification required in section 1(d) of this rule.

(L) Other information as required by the agency.

(3) Advanced Emergency Medical Technician provider organizations that do not also provide transportation of emergency patients shall submit and maintain a copy of a current written agreement between the nontransporting Advanced Emergency Medical Technician provider organization and an ambulance service provider organization certified under IC 16-31. The agreement shall:

(A) ensure that the nontransporting Advanced Emergency Medical Technician provider organization can be assured that patients treated shall be transported in a timely and safe manner; and

(B) not preclude another ambulance service provider organization, if available, from transporting the patients.

(C) Upon approval, an Advanced Emergency Medical Technician provider organization shall be issued certification for the provisions of advanced life support certification.

(4) The certificate:

(A) expires on the date appearing in the expiration date section of the certificate; and

(B) shall be prominently displayed at the place of business.

(C) An application for an Advanced Emergency Medical Technician provider organization certification renewal shall be made at least sixty (60) days before the expiration date of the current certification.

(5) Application for renewal shall:

(A) be made on forms provided by the agency; and

(B) show evidence of compliance with the requirements as set forth for original certification.

(Indiana Emergency Medical Services Commission; 836 IAC 2-7.2-2; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2355; filed Jun 11, 2004,
1:30 p.m.: 27 IR 3544; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA; readopted filed Jul 29, 2010, 8:07 a.m.: 20100825-IR-836100267RFA)

836 IAC 2-15-3 Advanced Emergency Medical Technician provider organization operating procedures
Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20
Affected: IC 16-31-3
Sec. 3. (a) Each Advanced Emergency Medical Technician provider organization shall do the following:
(1) Comply with the ambulance service provider operating procedures of 836 IAC 1-2-3. The Advanced Emergency Medical Technician provider organization nontransport provider organization shall comply with the operating procedures listed in 836 IAC 1-1-8.
(2) Establish daily equipment checklist procedures to ensure the following:
(A) Electronic and mechanical equipment are in proper operating condition.
(B) Emergency response vehicles are maintained in a safe operating condition at all times.
(C) All required medications and intravenous fluids approved by the medical director of the Advanced Emergency Medical Technician provider organization and the supervising hospital are on board all nontransport emergency medical services vehicles and ambulances when used for the provision of advanced life support and available to the Advanced Emergency Medical Technician.
(D) Equipment, medication, fluid, and supplies have not exceeded the manufacturer's specified expiration date.
(E) A copy of the medication list and protocols shall be maintained by the Advanced Emergency Medical Technician provider organization and the supervising hospital emergency department. Any changes to the medications list shall be forwarded to the agency within thirty (30) days.
(F) All medications and advanced life support supplies are to be supplied by order of the medical director. Accountability for:
(1) distribution;
(2) storage;
(3) ownership; and
(4) security;
of medications is subject to applicable requirements as determined by the medical director, pharmacist, and the United States Department of Justice Drug Enforcement Administration.
(3) The Advanced Emergency Medical Technician provider organization shall ensure the following:
(A) That stocking and administration of supplies and medications are limited to the Indiana Advanced Emergency Medical Technician curriculum and the following approved modules:
(i) Acquition and transmission of 12 Lead with continuing monitoring
(ii) Manual defibrillation
(iii) Acquition and interpretation of the five (5) rhythms
Ventricular Fibrillation
Ventricular Tachycardia
Asystole
Pulseless Electrical Activity
Normal Sinus
(iv) Non visualized airway
(v) Adult IO
(4) Procedures performed by the Advanced Emergency Medical Technician are also limited to the Indiana Advanced Emergency Medical Technician curriculum and the following approved modules:
(i) Acquition and transmission of 12 Lead with continuing monitoring
(ii) Manual defibrillation
(iii) Acquition and interpretation of the five (5) rhythms
Ventricular Fibrillation
Ventricular Tachycardia
Asystole
Pulseless Electrical Activity
Normal Sinus
(iv) Non visualized aiway

(v) Adult IO

(5) That all ambulances used for the provision of advanced life support contain the emergency care equipment required in 836 IAC 1-3-5, the rescue equipment required in 836 IAC 1-3-4, and communication equipment required in 836 IAC 1-4-2. The advanced life support emergency medical services vehicles shall also carry the following equipment:

(A) Portable defibrillator

(B) Intravenous fluids and administration supplies approved by the medical director, including pediatric and adult IO supplies.

(C) An Advanced Emergency Medical Technician provider organization and any affiliated Advanced Emergency Medical Technician possessing approval for intravenous line placement from the medical director may transport and treat a patient or patients from a health care facility as follows if:

(1) The only procedure that has been previously initiated for the patient is an intravenous line or lines administering prepackaged solutions of dextrose or electrolytes that contain one (1) or more of the following additives and no others:

(i) Vitamins.

(ii) Sodium chloride, excluding saline solutions in excess of nine-tenths percent (0.9%) concentration.

(iii) Potassium chloride (forty (40) milliequivalent per liter maximum).

(D) The ambulance contains sufficient quantities of the intravenous supplies and solutions received by the patient in order to:

(1) maintain the patient's established medical intervention; and to *[sic]*

(E) manage patient complications that may be reasonably anticipated to occur en route to the patient's destination.

(F) Medications and medical devices as approved by the medical director limited to the following:

(1) Baby aspirin, eighty-one (81) milligrams each.

(2) Oral glucose.

(3) Sublingual Nitroglycerine

(4) 1:1000 Epinephrine

(5) Glucagon

(6) Dextrose solution

(7) Inhaled beta agonist

(8) Narcotic (Opioid) antagonist

(9) Blood glucose monitor

(10) Pulse oximetry capable of adult and pediatric monitoring

(11) Length based pediatric resuscitation tape

(G)The following medications and medical devices as approved by the medical director may by carried:

(1) Cardiac monitor capable of any or all of the following:

(i) Continuous cardiac monitoring

(ii) Manual defibrillation

(iii) 12 Lead Acquisition and transmission

(2) Nitrous oxide

(3) Epinephrine auto-injector or auto-injectors

(6) A current copy of advanced life support protocols shall be maintained on board the emergency medical services vehicle at all times.

(7) A copy of the medication list, including quantities and concentrations approved by the medical director.

(8) The Advanced Emergency Medical Technician provider organization shall do the following:

(A) Ensure that all nontransport emergency medical services vehicles used for the provision of advanced life support meet all of the requirements in 836 IAC 2-14.

(B) Follow the rigid sanitation procedures listed in 836 IAC 1-1-8.

(9) An Advanced Emergency Medical Technician provider organization shall not do the following:

(A) Operate an ambulance or other emergency medical service vehicle unless it is in full compliance with this article.

(B) Transport any emergency patient or patient receiving advanced life support in any vehicle except an ambulance certified under IC 16-31.

(10) Advanced Emergency Medical Technicians are prohibited from having in their possession, or maintained on board emergency response vehicles, any advanced life support equipment or supplies that have not been approved by the Advanced Emergency Medical Technician provider organization medical director. *(Indiana Emergency Medical Services Commission; 836 IAC 2-7.2-3; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2356; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3545; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA; readopted filed Jul 29, 2010, 8:07 a.m.: 20100825-IR-836100267RFA)*

836 IAC 2-7.2-4 Application for provisional certification

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20
Affected: IC 4-21.5; IC 16-31-3-8; IC 16-31-3-20

Sec. 4. (a) An applicant may apply for and obtain provisional certification as an Advanced Emergency Medical Technician provider organization for the purpose of prehospital training of Advanced Emergency Medical Technician students when in the presence of a preceptor approved by the commission in accordance with this section.

(b) A provisional certification may only be issued to a certified ambulance service provider organization.

(c) The applicant shall submit a fully completed application for provisional certification on forms provided by the agency.

(d) The provisional certification may only be issued:

(1) after the applicant has demonstrated to the satisfaction of the director that the ambulance to be used for such training is certified and meets the requirements of this article; and

(2) if the ambulance service provider organization has and shall maintain an adequate number of Advanced Emergency Medical Technician students, preceptors, and ambulances to provide continuous twenty-four (24) hour advanced life support service.

(e) The provisional certification expires not later than the earlier of the following dates:

(1) Sixty (60) days after the completion date of the Advanced Emergency Medical Technician course completion as identified on the approved course application.

(2) Twenty-four (24) months from the starting date of the course contained on the approved course application.

(f) The issuance of an Advanced Emergency Medical Technician provider organization certification invalidates any provisional certification. *(Indiana Emergency Medical Services Commission; 836 IAC 2-7.2-4; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3547; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA; readopted filed Jul 29, 2010, 8:07 a.m.: 20100825-IR-836100267RFA)*

Attachment #4

Training Institution Psychomotor Examination Guidelines

This section of the manual will outline the requirements to become a State approved Training Institution, the requirements during an examination, and the ongoing requirements needed to maintain the status of a Training Institution.

All Training Institutions

FOREWORD

This section of the manual was adopted from the National Registry of Emergency Medical Technicians by the Emergency Medical Services Commission as a result of their continued awareness, and the need for standardized and uniform criteria for psychomotor examinations. The evolution of psychomotor examinations has been guided by many changes within emergency medical services in the United States. When EMT training began in the early 1970's, there were relatively few people with an in-depth knowledge of the spectrum of emergency medical care, limited types of equipment and one training standard. Since then, situations have changed and thus standardization is becoming more difficult to attain. Emergency medical care has evolved into a recognized body of knowledge and skill, multiple approaches for accomplishing a task have been advocated in peer journals and a variety of methods for the use of standard equipment have been suggested by equipment manufacturers. Because of this situation, there are currently multiple ways to perform a skill, conduct a psychomotor examination, and define competency. Therefore, because standardization has become more difficult in the assessment of psychomotor skills, the EMS Commission has adopted this document as a tool to assess psychomotor comp.

Completed in 2009, the National EMS Education Standards represents another step toward realizing the vision of the *1996 EMS Agenda for the Future*, as articulated in the *2000 EMS Education Agenda for the Future: A Systems Approach*. The *Standards* define the minimal entry-level educational competencies for each level of EMS personnel as identified in the *National EMS Scope of Practice Model*. Eventually, the *Standards* will replace the current DOT National Standard Curricula (NSC). The less rigid *Standards* format supports diverse implementation methods and more frequent content updates.

At NO time may local medical direction or training officials choose to alter the format or design of the examination or the Psychomotor Exam Sheets in order to meet local protocols or constraints.

If the examination is being given for the purpose of fulfilling National Registry entry requirements, candidates must be deemed competent in the mandatory stations and the random psychomotor station. The National Registry will continue to accept state-approved psychomotor examinations provided they meet or exceed the criteria presented by the National Registry. The format of the Indiana State EMR/EMT Psychomotor Examination meets all National Registry requirements.

The Indiana State Emergency Medical Services Commission and the National Registry is dedicated to the goal of establishing a standardized, valid psychomotor examination that can be utilized from state to state, across the nation. As we work toward this goal, we welcome your comments concerning this examination and its format. Please address all comments to the Indiana EMS Commission, Indiana Government Center-South room E-239, 302 W. Washington St., Indianapolis, Indiana 46204

Introduction

With the development of the National Scope of Practice and National Education Standards (NES), the National Registry of EMTs adopted updated psychomotor exam forms in 2012. Effective in 2013, the Indiana EMS Commission approved a compliant version of the National Registry of EMTs forms. These forms relate to psychomotor skills that an EMR/ EMT would likely utilize in day-to-day pre-hospital care as well as the criticality of the skill in relationship to public safety and patient care. The following eleven (11) psychomotor skills were identified as being the performance items that could be included in a psychomotor examination.

Patient Assessment Management - Trauma

Patient Assessment Management - Medical

Cardiac Arrest Management/AED

BLS Airway Management

Spinal Immobilization - Supine Patient

Spinal Immobilization - Seated Patient

Long Bone Injury Immobilization

Joint Injury Immobilization

Traction Splint Immobilization

Bleeding Control/Shock Management

Oxygen Preparation and Application

Ventilation and Airway Management of the Apneic Patient (E.M.R. Candidates)

These psychomotor skills reflect performance items that are directly related to the loss of life or limb. Therefore, the major focus of the examination is on airway, breathing, circulation and immobilization skills.

The EMS Commission identified the following criteria that must be met for a performance examination to be used statewide:

Each task on the Psychomotor Exam Sheets must be scored as a separate task.

All items critical to patient/limb outcome must be identified on the exam sheet.

Sequencing of tasks in some instances must be considered critical behavior.

Overall competency must be achieved as defined in this manual.

The Psychomotor Exam Sheets provided in this guide were developed to meet the above criteria.

The Psychomotor Examination Skill Examination sheets shall be furnished by the agency or institution hosting the skill examination. The examination host shall furnish a sufficient quantity and required colors as noted below for initial tests and possible retests for each candidate.

PSYCHOMOTOR SKILLS SHEETS

The following are highly recommended colors for Skill Sheet copies. This is to expedite the processing of the psychomotor paperwork in an efficient and uniform manner.

Trauma: shade of tan or off-white
Medical: Shade of lavender or purple
Cardiac Arrest/AED: Shade of pink or red
BLS Airway Management: Shade of light blue
Spinal Seated: Shade of light green
Spinal Supine: Shade of light yellow
Random Basic: White or gray copies of each random station

The National Registry of Emergency Medical Technician was sensitive to input received, requesting the National Registry to develop an administratively feasible and cost effective psychomotor examination. The EMT Psychomotor Examination Committee and the National Registry Board of Directors considered the following factors when developing and approving this Psychomotor Examination User's Guide:

Protection of the public is the primary responsibility of the National Registry of Emergency Medical Technicians and all certifying agencies.

The current NHTSA EMT training curriculum contains scheduled psychomotor skills laboratories.

The National Registry and many states have been using limited random psychomotor stations with success and have found that they reduce cost without reducing the quality of the examination.

Training programs are responsible for assuring competency of candidates seeking National Registration. Candidates deemed incompetent by the training program should not be permitted to take this Psychomotor Examination.

Outside verification by agencies or individuals not directly associated with the training program must be accomplished in order to assure protection of the public.

A totally random psychomotor examination is not acceptable and does fulfill all of the criteria listed above. When using this psychomotor examination for Indiana State Certification and National Registration.

Best Practice

The training program measures and documents the candidate's competency in all psychomotor skills included in the mandatory and random psychomotor stations. This must be accomplished prior to allowing a candidate to attempt the psychomotor examination used for certification.

Examination Stations

The EMR Psychomotor Examination consists of five (5) stations – Four (4) mandatory stations and one (1) random station. The EMT psychomotor examination consists of seven (7) stations -- Six (6) mandatory stations and one (1) random station. The mandatory and random stations consist of both skill based and scenario based testing. The random station is conducted so the candidate is totally unaware of the skill to be tested until he/she arrives at the station.

The candidate will be tested individually in each station and will be expected to direct the actions of any assistant who may be present in the station. The candidate should pass or fail the examination based solely on his/her actions and decisions.

The following is a list of the stations and their established time limits. The maximum time is determined by the number and difficulty of tasks to be completed:

EMR	Skill to be Tested	Maximum Time Limit	Number of Staff Needed
Station 1:	Patient Assessment Management - Trauma	10 minutes	Evaluator, Patient
Station 2:	Patient Assessment Management - Medical	10 minutes	Evaluator, Patient
Station 3:	Cardiac Arrest Management/AED	10 minutes	Evaluator, Assistant
Station 4:	Spinal Immobilization- Supine	10 minutes	Evaluator, Assistant, Patient
Station 5:	One Random Basic Skill listed below:		
	Long Bone Injury Immobilization	5 minutes	Evaluator, Patient
	Bleeding Control/Shock Management	10 minutes	Evaluator, Patient
	Ventilation and Airway Management of the Apneic Patient	5 minutes	Evaluator
	Oxygen Preparation and Application	5 minutes	Evaluator

EMT	Skill to be Tested	Maximum Time Limit	Number of Staff Needed
Station 1:	Patient Assessment Management - Trauma	10 minutes	Evaluator, Patient
Station 2:	Patient Assessment Management - Medical	10 minutes	Evaluator, Patient
Station 3:	Cardiac Arrest Management/AED	10 minutes	Evaluator, Assistant
Station 4:	BLS Airway Management	10 minutes	Evaluator
Station 5:	Spinal Immobilization- Supine	10 minutes	Evaluator, Assistant, Patient
Station 6:	Spinal Immobilization - Seated Patient	10 minutes	Evaluator, Assistant,

			Patient
Station 7:	One Random Basic Skill listed below:		
	Long Bone Injury Immobilization	5 minutes	Evaluator, Patient
	Joint Injury Immobilization	5 minutes	Evaluator, Patient
	Traction Splint Immobilization	10 minutes	Evaluator, Patient
	Bleeding Control/Shock Management	10 minutes	Evaluator, Patient (real or hard shell mannequin)
	Oxygen Preparation and Application	5 minutes	Evaluator

Random Skill Selection

The random psychomotor skill that is to be tested will be randomly chosen at the beginning of the psychomotor exam for all candidates.

If a candidate fails the random skills station, then the candidate will retest the same random skills station.

Best Practice

Cards with random skill stations can be drawn by evaluators.

Selection of an Examination Facility

All exams must be conducted by an IDHS approved Training Institution. It is important that the testing stations are set up in such a way to prevent candidates from seeing or hearing other stations. The facility should have a waiting area large enough to accommodate the number of candidates scheduled to attempt the examination. The waiting area should have chairs or benches, access to rest rooms and drinking sources as well as adequate storage space for examination supplies. Arrangements for meals and other breaks for staff members and candidates is an additional consideration. A secured room must be provided for the examinations coordinator or the state examination representative. This room should have a suitable work area to grade the examinations.

Community facilities with available space may include schools, office buildings, hospitals, fire stations and other structures which will meet the criteria described above.

Selection of the Examination Staff

One of the major considerations in the selection of examination staff members is their enthusiasm and interest in the examination. The examination procedure is demanding and time-consuming. Therefore, without full cooperation from the staff members, it will be difficult to conduct the repeated evaluations necessary for a large group of candidates.

Whenever possible, it is recommended to form a core group of regular examination personnel. This will help promote teamwork and consistency among the examination staff. It has been our experience that the more frequently a group works together, the more smoothly and effectively the examination runs; however, all examination personnel should be fully aware of their responsibilities as Psychomotor Station Examiners.

Psychomotor examiners should be recruited from the local EMS community. You should only consider individuals who are currently certified to the EMS level or above the skill level in which they are evaluating. Careful attention must be paid to avoid possible conflicts of interest, local political disputes or any pre-existing condition(s) which could bias the potential examiner towards a particular individual or group of individuals. **In no instance should the course primary instructor or lead instructor serve as a Psychomotor Station Examiner.** Casual members of the instructor staff may be utilized, if necessary, provided there is no evidence of bias and they do not evaluate any psychomotor skills for which they served as the instructor.

If a candidate has concerns with the objectivity of an evaluator, the candidate must notify the State Representative prior to being evaluated. The State Representative will address each notification on a case by case basis.

Every effort should be made to select examiners who are fair, consistent, objective, respectful, reliable and impartial in conduct and evaluation. Examiners should be selected based on their expertise in the skill to be evaluated.

Examiners must understand that there is more than one acceptable way to perform a skill and should not indicate a bias that precludes acceptable methods. All examiners should have experience working with EMT's, teaching or formal evaluation of pre-hospital care.

It is highly recommended that a **minimum** EMR examination should consist of five (5) psychomotor skill station examiners, four (4) programmed patients, and three (3) assistants. It is highly recommended that a **minimum** EMT examination staff should consist of seven (7) psychomotor skill station examiners, five (5) programmed patients, four (4) assistants to the ratio of fifteen (15) candidates.* There must be one (1) examination coordinator (preferably the course primary instructor).

It is recommended one individual is available for moulage purposes. The candidate ratio to testing stations is recommended to be 16-30 candidates should have a minimum of (14) stations, **minimum** (2) of each station.

Responsibilities of the Examination Staff

The psychomotor skills to be tested and the acceptable levels of performance should always be determined with physician medical director input. Physician medical director should be available by telephone, pager, or have a designated physician to serve in his/her absence.

The Examination Coordinator is responsible for the overall planning, implementation, equipment for the examination process. The State Examination Representative/ Examination Coordinator is responsible for the quality control and validation of the examination process according to the rules set forth by the Indiana Emergency Medical Services Commission. Specific duties include orientation of the candidates, the skill station examiners, grading of all report sheets, and reporting of examination results to the Indiana Emergency Medical Services Staff. **Examination results and all report forms must be submitted within five (5) working days from the date of the examination.**

Skill station examiners observe candidate performance and complete psychomotor exam sheets. With input from programmed patients, they also make an initial evaluation of a candidate's performance. In the interest of fairness and objectivity, instructors shall not examine their own candidates. Examiners must maintain a professional and impartial attitude at all times. This not only creates an environment of fairness to the candidate, it also assists in creating a more realistic atmosphere. Examiners may be selected from a fairly wide range of resources. For example, local physicians, nurses, paramedics, and experienced EMTs provide potential examination staffing.

Assistants should be knowledgeable in the skill that they are assisting. They are required to perform as trained EMS professionals would in an actual field situation. They should follow the direction of the EMR/EMT candidate and may not coach the candidate relative to the performance of any skill.

The programmed patient's performance is also extremely important. A lack of uniformity in performance by a programmed patient may cause a variance in the candidate's ability to identify and treat an injury correctly. In addition, an informed programmed patient frequently is able to evaluate certain aspects of a candidate's proficiency not readily observed by the examiner.

Attempts should be made to ensure that programmed patients are experienced EMS personnel and/or other allied health personnel. The advantages of this approach are that prior patient contact enables the

programmed patient to re-enact injuries more accurately and to evaluate appropriate or inappropriate behavior/technique by the candidate.

Moulage personnel are responsible for realistically simulating wounds. This realism has a great deal of influence on the candidate's actions during the examination. Virtually any type of wound can be realistically reproduced with moulage by using the right materials, common sense and a little practice.

Equipment

The supplies and equipment needed to prepare each of the examination stations are listed in this manual. Each examiner will need a watch and a supply of psychomotor exam sheets to score each candidate's performance.

Best Practice

The funds required to conduct an examination will vary. The exact cost will depend on the availability of volunteers to staff the examination and the degree of other community support such as donations of space and supplies. Equipment can usually be borrowed from local rescue agencies or hospitals. Equipment from a certified emergency vehicle shall not be removed for use in the examination process.

Orienting the Psychomotor Station Examiners as a Group

An important component of ensuring that the examination operates smoothly is orienting the Psychomotor Station Examiners to their role and responsibilities during the examination process. In order to ensure the consistent performance of examiners throughout the day, the examiners should be assembled as a group prior to the start of the examination and instructed in the procedures of the examination according to a standardized orientation script in this manual.

Orienting the Candidates as a Group

An important aspect of the examination is the initial meeting and orientation of the candidates. Once all candidates have been registered for the examination, they should be assembled as a group and instructed in the procedure of the examination according to a standard orientation script in this manual. During this

period, the candidates should be given clear and complete directions as to what is expected of them during the examination. However, special effort should be made to put the candidates at ease. It is during this period that questions regarding the examinations should be solicited and answered.

During this orientation session, candidates should also be instructed to leave the testing area immediately upon completion of their examination and to not discuss the examination with those candidates waiting to be tested.

Orienting the Individual

Following the group orientation, candidates will wait for directions to report to a specific testing area. Prior to entering these areas, the candidates are greeted by the examiner and read the "Instructions to the Candidate" as they appear at the end of each psychomotor exam essay provided by the Examination Coordinator. To assure consistency and fairness, these instructions should be read to each candidate exactly as written. Each candidate should then be questioned as to his/her understanding of the instruction and provided with clarification as required.

Caution must be used to avoid lengthy questions or attempts by the candidate to obtain answers to questions which have no bearing on the examination. Examiners should be courteous and professional in all conversations with candidates.

Minimum Required Equipment List

Patient Assessment/Management (Trauma)	
*Examination Gloves Pen light Blood pressure cuff Stethoscope Moulage	One (1) Evaluator One (1) Patient
Patient Assessment/Management (Medical)	
*Examination Gloves Pen light Blood pressure cuff Stethoscope Moulage	One (1) Evaluator One (1) Patient
Cardiac Arrest Management/AED	
*Examination Gloves CPR mannequin **Oxygen tank, regulator and flow meter Automated external defibrillator trainer	Bag-valve-mask device or pocket mask Simple airway adjunct (OPA/NPA) in multiple sizes
BLS Airway Management	
*Examination Gloves Oropharyngeal airways (various sizes) Handheld or powered suction unit with catheter tips Bag-valve-mask device	Oxygen tank, regulator and flow meter Oxygen connecting tubing Intubation mannequin (Must be anatomically accurate) Supraglottic / Non-visualized airway
Spinal Immobilization (Seated Patient)	
*Examination Gloves	Head immobilizer (commercial or improvised)

Short spine immobilization device (short board, KED, etc.) Cervical collars (various sizes or adjustable)	Padding (i.e. towels, cloths) Patient securing straps Roller gauze or cravats Tape
Spinal Immobilization (Supine Patient)	
*Examination Gloves Long spine immobilization device (i.e. long spine board) Cervical collars (various sizes or adjustable)	Head immobilizer (commercial or improvised) Padding (i.e. towels, cloths) Patient securing straps Roller gauze or cravats Tape
Random Station	
*Examination Gloves Filled oxygen tank, regulator and flow meter Oxygen connecting tubing Nasal cannula Non-rebreather mask with reservoir Artificial mannequin or limb for tourniquet application (hard shell)	Mannequin Traction Splint and associated equipment EMT only Sling and swathe Various splinting material (various sizes) Field dressings and bandage Suitable tourniquet dressings and torquing device or commercial device Blanket

*Exam gloves to be available for each station or in the staging area.

** Preferred item for testing station may be simulated if limited supply.

A. *Roles and Responsibilities of the Indiana Psychomotor Exam Coordinator*

Reservation requirements(if not part of course application)	
At least 30 days prior to the date of the psychomotor exam: Ensure Candidates have a PSID number. Complete and submit the Psychomotor Exam Reservation Form and Candidate Roster with PSID numbers.	
Room Set-up (Best Practice)	
EMT - For every set of stations (15 candidates)	EMR - For every set of stations (15 candidates)
1 for Patient Assessment Management- Trauma 1 for Patient Assessment Management- Medical 1 for Cardiac Arrest Management/ AED 1 for BLS Airway Management 1 for Spinal Immobilization – Supine Patient 1 for Spinal Immobilization – Seated Patient 1 for Random Basic Skill Station 1 for the candidates 1 for the evaluators 1 for the Psychomotor Exam Representative	1 for Patient Assessment Management - Trauma 1 for Patient Assessment Management - Medical 1 for Cardiac Arrest Management/AED 1 for Spinal Immobilization- Supine 1 for Random Basic Skill Station 1 for the candidates 1 for the evaluators 1 for the Psychomotor Exam Representative
Equipment/Supply requirements	
One set of equipment is recommended for every 15 candidates completing the full psychomotor exam. Refer to the corresponding section for the list of required equipment by station. Copy the Psychomotor Exam Sheets per the color code listed in the Training Manual and the Face Sheet with the "What You Need to Know" printed on the reverse side. Copy enough forms for every candidate to complete the station twice. Copy one set of station instructions for each station.	
Staffing recommendations	

EMT - For every set of stations	EMR - For every set of stations
7 Qualified Station Examiners 5 People as Patients 4 assistants 1 Person as moulage person 1 Person to monitor the staging area at all times and send candidates to the skill stations Refer to the Training Manual for the list of recommended staffing	5 Qualified Station Examiners 3 People as Patients 3 Assistants 1 Person as moulage person 1 Person to monitor the staging area at all times and send candidates to the skill stations Refer to the Training Manual for the list of recommended staffing

Best Practice

It is recommended to print a sheet of labels for each candidate (enough for the required amount of stations being tested) and give to candidates. Instruct candidates to give a label to each evaluator upon entering the skill station. If you do not use labels, make sure that each person legibly writes their name on the psychomotor exam sheets.

Candidate Preparation
Review the "What You Need to Know as an Indiana EMR / EMT Psychomotor Exam Candidate" document with the candidates. This document can be found in the Psychomotor Exam Packet. Instructors are encouraged to provide the Psychomotor Exam Packet to candidates at the beginning of the course and reference it throughout the course. Advise candidates to bring a state issued picture identification and black ink pen to the Psychomotor Exam.
Day of the Psychomotor Exam
All equipment/stations, evaluators and candidates should be ready to begin upon arrival of the Psychomotor Exam Representative.
Verify sufficient staffing, equipment and stations for the number of candidates testing.
Verify all equipment is working properly and that all required equipment is in each skill station.
Have evaluators sign in and document their PSID numbers or credentials for the Psychomotor Exam Representative. Evaluators must be currently qualified to evaluate the station they are assigned.
Ensure all candidates have their state issued picture identification ready for the Psychomotor Exam Representative.
Ensure that the Psychomotor Exam Representative room remains secured throughout the entire exam. This room is exclusively for the Representative, and **no one** should enter this room without explicit permission from the Representative
Verify that the candidate waiting area will always be monitored and that candidates are being sent to the stations in a timely manner.
Assist the Psychomotor Exam Representative in collecting completed evaluation forms per the direction of the Representative.
In collaboration with the Psychomotor Exam Representative, determine whether retests will be offered. The preference is to allow retests. However, you may choose to not offer retests if there are an excessive number of retests, if staffing has fallen too low, if time does not permit, or any situation has arisen that would make offering retests impractical.
If retests will be offered, assign new evaluators to the skill stations being retested and assist the Psychomotor Exam Representative in distributing station paperwork at the direction of the Representative.
Under the direction of the Psychomotor Exam Representative, bring candidates to obtain their exam results.

After the Psychomotor Exam
Review the completed Psychomotor Exam Quality Control Checklist with the Psychomotor Exam Representative.
Complete the Psychomotor Exam Representative evaluation when it is received from IDHS.

B. Evaluating the Candidate

Examiner's Role

It is stressed again that the examiners must be objective and fair in their scoring. An examiner may not evaluate any psychomotor skill for which he/she was the instructor. The primary instructor for the course as well as any core instructors may not function as a psychomotor skill evaluator for their candidates.

Using the Psychomotor Examination Sheets

The evaluation process consists of the examiner at each station observing the candidate's performance and recording it on a standardized Psychomotor Exam Sheet. The examiner's role becomes that of an observer and recorder of events. Psychomotor Exam Sheets have been developed for each of the testing stations. Additionally, essays explaining each psychomotor skill have been developed to assist the examiner with the appropriate use of the instrument. These essays are listed in the last section of the manual.

Except to start or stop a candidate's performance, to deliver necessary cues (e.g., "The patient's blood pressure is 100/40; pulse is 120 and thready.") or to ask for clarification, the examiner should not speak to the candidate during his/her performance. Similarly, the examiner should not react, either positively or negatively, to anything the candidate says or does.

Programmed Patient's Role

The programmed patient is responsible for an accurate and consistent portrayal as the victim in the scenario for the station. The programmed patient's comments concerning the candidate's performance can be noted on the reverse side of the performance exam sheet. These comments should be as brief and as objective as possible so they can be used in the final scoring of the candidate's performance when appropriate.

Determining a Final Grade

Scoring

As mentioned earlier, the psychomotor station examiners observe the candidate's performance and record the observations on the exam sheet. These exam sheets are collected, brought directly to the State Examination Representative, and graded by the Indiana State Examination Representative according to the pass/fail criteria provided by the testing agency.

It should be noted that there are two Critical Criteria that deal with the affective domain, which measures the candidate's attitudes, behaviors, and professional attributes. The best place for "constructive criticism" is in the classroom and clinical phases of education—not during the examination process. A failure of a Critical Criteria for an affective or behavior based performance issue should be reserved for an egregious behavior that is serious enough that it would result in harsh disciplinary action in most EMS systems. The affective performance based criteria are "Failure to manage the patient as a competent EMT" and "Exhibits unacceptable affect with patient or other personnel." While this document cannot identify all of the forms of behavior, some of the behaviors that would be unacceptable are listed below. Any failure of a Critical Criteria relating to affective domain should be based upon a clearly defined "offensive" observation by the evaluator and not just "unreasonable" behaviors.

The following list should be used as a guide. IT is not intended to be exclusive as potential Critical Criteria level of behaviors:

Fails to behave with INTEGRITY. Unacceptable would be any form of cheating during the testing process, lying during the testing process, or deliberate disrespectful/ insubordinate behavior towards the patient, assistants, or evaluator.

Lack of EMPATHY or failure to treat the simulated patient in a calm, compassionate manner. Unacceptable examples would be deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance. Inappropriately fitting clothing or grooming are examples.

Lack of COMMUNICATION that impedes patient evaluation or care. Examples would include failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of RESPECT for the patient or other assistants includes no deliberate demeaning terms or derogatory language.

In most cases, the pass/fail will be easily determined. If, however, the pass/fail determination of official criteria is not easily identified, the Examination Coordinator and the Indiana State Examination Representative should review the situation as a committee before coming to a final decision, and, if necessary, they should contact the Medical Director. The programmed patient's comments, the examiner's comments and the documentation on the exam sheets should all be considered when determining whether a critical criterion was met.

Once the individual exam sheets have been scored, the State Psychomotor Examination Representative should transcribe the individual station results onto the Psychomotor Examination Report Form. The

Indiana Psychomotor Examination Report Form is then used to determine and record the overall score of the Psychomotor Examination.

Reporting Examination Results to the Candidate

The State Psychomotor Examination Representative is responsible for reporting the unofficial psychomotor examination results to the individual candidate. A copy of the Indiana Psychomotor Examination Report Form could be used for this purpose. At no time should the station examiner notify the candidate of examination results. Notifying candidates of failing performances prior to completion of the entire Psychomotor Exam may have an adverse effect on their performance in subsequent stations.

The results of the Psychomotor Examination should be reported as a pass/fail of the station. At no time should the candidate be allowed to review the completed Psychomotor Exam sheets. Identifying errors is not only contrary to the principles of this type of examination, but it could result in the candidate "learning" the examination while still not being competent in the necessary skills.

All forms of the Indiana Psychomotor Examination must be submitted to the Indiana Emergency Medical Services Commission Staff (IDHS) for formal processing.

Assuring Standardization and Quality Control

To be reliable, a psychomotor examination must be conducted according to a uniform set of criteria. These control criteria must be rigidly applied to all aspects of the examination if impartial, objective, and standardized scoring is to be assured.

The State Psychomotor Examination Representative must validate the standardization and quality control of the examination process by completing the Quality Control Checklist provided with the Psychomotor Examination Packet (email).

Orientation Script

This script should be read before each examination session. The script is to be read by the State Psychomotor Examination Representative, who should maintain a friendly and professional attitude.

GENERAL INSTRUCTIONS TO THE CANDIDATES

Welcome to the Indiana EMR/EMT Psychomotor Examination. My name is ____. I will be serving as the Indiana Psychomotor Examination Representative today. By successfully completing this examination process and receiving subsequent certification, you will have proven to yourself and the medical community that you have achieved the level of competency assuring that the public receives quality pre-hospital care.

Please note: No personal electronic devices are permitted in the building. These must either be left in your vehicle or at home.

The station examiners utilized today are state certified and or licensed personnel and are observers and recorders of your expected appropriate actions. They record your performance in relationship to the criteria listed on the exam sheets approved by the National Registry of EMTs and the Indiana EMS Commission.

The station examiner will call you into the station when it is prepared for testing. **NO** candidate, at any time, is permitted to remain in the testing area while waiting for his/her next station. You must wait outside the testing area until the station is open and you are called. You are not permitted to take any books, pamphlets, brochures or other study material into the station. You are not permitted to make any copies or recordings of any station. When the examiner asks your name, please assist him/her in spelling your name so that your results may be recorded accurately, or provide him/her with the pre-printed sticker provided to you by staff. Do not use nicknames.

If you have concerns with the objectivity of an evaluator, you must notify me prior to being evaluated. I will address each notification on a case by case basis.

Please pay close attention to the instructions, as they correspond to dispatch information you might receive on a similar emergency call and give you valuable information on what will be expected of you during the station. The station examiner will offer to repeat the instructions and will ask you if the instructions were understood. Do not ask for additional information not contained within the instructions, as the station examiner is not permitted to give this information.

We have instructed the station examiners not to indicate to you in any way a judgment regarding your performance in the station. Do not interpret any of the examiners remarks or documentation practices as an indication of your overall performance. Please recognize the station examiner's attitude as professional and objective, and simply perform the skills to the best of your ability.

You will be given time at the beginning of the station to survey and select the equipment necessary for the appropriate management of the patient. Do not feel obligated to use all the equipment. If you brought any of your own equipment, I must inspect and approve it before you enter the station.

The station examiner does not know or play a role in the establishment of pass/fail criteria, but is merely an observer and recorder of your actions in the station. This is an examination experience, not a teaching or learning experience.

Each station has an overall time limit; the examiner will inform you of this during the reading of the instructions. When you reach the time limit, the station examiner will inform you to stop your performance. However, if you complete the station before the allotted time, inform the examiner that you are finished. You may be asked to remove equipment from the patient before leaving the station.

You are not permitted to discuss any details of any scenario with each other at any time. Please be courteous to the candidates who are testing by keeping all excess noise to a minimum. Be prompt in reporting to each station so that we may complete this examination within a reasonable time period.

Failure of less than the majority of stations (as noted on the skills cover sheet) may allow you to retest of those stations failed if offered by the examine coordinator and the candidate elects to retest Failure of the majority of stations constitutes complete failure of the entire psychomotor examination, requiring a retest of the entire psychomotor examination after remedial training. Failure of a same-day retest entitles you to a retest of those skills failed. **This retest must be accomplished at a different date and test site, with a different examiner.** Failure of the retest at the different site constitutes a complete failure of the psychomotor examination, and you will be required to retest the entire psychomotor examination after providing proof of remedial training to the Indiana Emergency Medical Services Commission. A candidate is allowed to test a single station a maximum of three (3) times before he/she must retest the entire psychomotor examination. Any retest of the entire psychomotor examination requires the candidate to document remedial training over all skills before re-attempting the examination. Failure to pass all stations by the end of two (2) full examination attempts constitutes a complete failure of the skills testing process. Therefore, you must complete a new EMR/EMT training program to be eligible for future testing for certification. NOTE: You have one (1) year from your EMR/EMT course completion date to successfully complete all phases of the psychomotor examination process.

The results of the psychomotor examination are reported as a pass/fail of the skill station. You will not receive a detailed critique of your performance on any skill. Please remember that today's examination is a formal verification process and was not designed to assist with teaching or learning. Identifying errors will be contrary to the principle of this type of examination, and could result in the candidate "learning" the examination while still not being competent in the necessary skill.

If you feel you have a complaint concerning the examination, a formal complaint procedure does exist. Complaints must be initiated with me before you learn of your results or leave this site. You may file a complaint for only two (2) reasons:

You feel you have been discriminated against. Any situation in which you feel an unfair evaluation of your abilities occurred may be considered discriminatory.

There was an equipment problem or malfunction in your station.

If you feel either of these two things occurred, you must contact me immediately to initiate the written complaint process. The Indiana Psychomotor Examination Representative, Examination Coordinator and, if warranted, the Medical Director will review your concerns.

I am here today to assure that a fair, objective, and impartial testing process occurs. If you have any concerns, notify me immediately to discuss them. I may be visiting stations throughout the examination to verify appropriate testing procedures.

Does anyone have any questions concerning the psychomotor examination at this time?

POINTS TO REMEMBER

Follow instructions from the staff.

During the examination, move only to areas directed by the staff.

Give your full legal name as you arrive at each station.

Listen carefully as the testing scenario is explained at each station.

Ask questions if the instructions are not clear.

During the examination, do not talk about the examination with anyone other than the station examiner, programmed patient and, when applicable, to the trained assistant.

Be aware of the time limit, but do not sacrifice quality performance for speed.

Equipment will be provided. Select and use only that which is necessary to care for your patient adequately.

Read roster and Check ID's

Programming the Patient

Patient programming involves two essential elements: acting and medical input as to the type of injury, type of pain, general reaction and what should and should not be accomplished by the EMR/ EMT candidate.

It is not necessary to have professional actors as programmed patients. Almost anyone with the proper motivation can do an excellent job. If the programmed patient really believes in the scenario, it will become believable to others; however, patients with a working knowledge of EMS are preferred and recommended.

Once the programmed patient has received the medical information on the type of injury or illness, he/she should concentrate on how he/she personally reacts to pain. The programmed patient should work with the medical personnel until he/she has fully developed the proper reactions and responses. Medical personnel should always use lay terms in programming the patient, and the patient should always respond in lay terms to any questions from the candidate. After the patient has been fully "programmed," it is essential that he/she stay in character, regardless of what goes on around him/her.

Input from the programmed patient with respect to the way candidates handle him/her is important in the scoring process. This should be strongly emphasized to the programmed patient.

Moulage

Moulage of simulated patients is important if the Training Institution is expecting candidates to identify wounds readily. The sample psychomotor examination only requires moulage in the Patient Assessment/Management stations. Although theatrical moulage is ideal, commercially available moulage kits are acceptable in alerting the candidate to the presence of injuries on the simulated patient.

Regardless of the quality of moulage, examiners must communicate with the candidate concerning information on wound presence and appearance. Candidates will need to distinguish between venous and arterial bleeding, paradoxical chest movement, obstruction of the airway and any other injury that a programmed patient cannot realistically simulate. If candidates complain about the quality of moulage, the Coordinator should objectively re-examine the quality of the moulage. If the quality of the moulage is deemed to be marginal and does not accurately represent the wound, the Coordinator should instruct the station examiner to alert candidates to the exact nature of the injury.

The station examiner should do this only after the candidate has assessed the area of the wound as would be done in an actual field situation.

PSYCHOMOTOR EXAM GUIDELINES-Trauma

Instructions to the Evaluator

This station is designed to test the candidate's ability to integrate patient assessment and intervention skills on a victim with multi-systems trauma. Since this is a scenario based station, it will require some dialogue between the examiner and the candidate. The candidate will be required to physically accomplish all assessment steps listed on the exam sheets. However, all interventions should be spoken instead of physically accomplished. Because of the limitations of moulage, you must establish a dialogue with the candidate throughout this station. If a candidate quickly inspects, assesses or palpates the patient in a manner in which you are uncertain of the areas or functions being assessed, you must immediately ask the candidate to explain his/her actions. For example, if the candidate stares at the patient's face, you must ask what he/she is assessing to precisely determine if he/she was checking the eyes, facial injuries or skin color. Any information pertaining to sight, sound, touch, smell, or an injury that cannot be realistically moulaged but would be immediately evident in a real patient encounter must be supplied by the examiner as soon as the candidate exposes or assesses that area of the patient.

This station requires the presence of a simulated trauma victim. The victim should be briefed on his/her role in this station as well as how to respond throughout the assessment by the candidate. Additionally, the victim should have read thoroughly the "Instructions to the Simulated Trauma Victim." Trauma moulage should be used as appropriate. Moulage may range from commercially prepared moulage kits to theatrical moulage. Excessive/dramatic use of moulage must not interfere with the candidate's ability to expose the victim for assessment.

The victim will present with a minimum of an airway, breathing, circulatory problem and one associated injury or wound. The mechanism and location of the injury may vary, as long as the guidelines listed above are followed. It is essential that once a scenario is established for a specific test station, it remains the same for all candidates being tested at that station. This will ensure consistency of the examination process for all candidates.

Candidates are required to conduct a scene size-up just as they would in a field setting. When asked about the safety of the scene, the examiner must indicate the scene is safe to enter. If the candidate does not assess the safety of the scene before beginning patient care, no points should be awarded for the task "Determines the scene is safe".

An item of some discussion is where to place vital signs within a pre-hospital patient assessment. Obtaining precise agreement among various EMT texts and programs is virtually impossible. Vital signs have been place in the focused history and physical. This should not be construed as the only place that

vital signs may be accomplished. It is merely the earliest point in a pre-hospital assessment that they may be accomplished.

The scenario format of a multi-trauma assessment/management testing station requires the examiner to provide the candidate with essential information throughout the examination process. Since this station uses a simulated patient, the examiner must supply all information pertaining to sight, sound, smell or touch that cannot be adequately portrayed with the use of moulage. This information should be given to the candidate **when the area of the patient is exposed or assessed.**

The candidate may direct the trained assistant to obtain patient vital signs. The examiner must provide the candidate with the patient's pulse rate, respiratory rate and blood pressure when asked.

Due to the scenario format and voiced treatments, a candidate may forget what he/she has already done to the patient. This may result in the candidate attempting to do assessment/intervention steps on the patient that are physically impossible. For example, the candidate may have voiced placement of a cervical collar in the initial assessment and then later, in the detailed physical examination, attempt to evaluate the integrity of the cervical spine. Since this cannot be done without removing the collar, you, as an examiner, should remind the candidate that previous treatment prevents assessing the area. This same situation may occur with splints and bandages.

Each candidate is required to complete a detailed physical examination of the patient. The candidate choosing to transport the victim immediately after the initial assessment must continue the detailed physical examination enroute to the hospital. You should be aware that the candidate may accomplish portions of the detailed physical examination during the rapid trauma assessment. If the candidate fails to assess a body area prior to covering the area with a patient care device, no points should be awarded for the task. However, if a candidate removes the device assesses the area and replaces the device without compromising patient care; full points should be awarded for the specific task.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Simulated Trauma Patient

Note: In order to ensure a fair examination environment for each candidate, the simulated victim should be an adult of average height and weight. For example, the use of very small children is discouraged in this station.

The following should be reviewed by the station examiner with the person serving as victim.

When serving as a victim for the scenario today make every attempt to be consistent with every candidate in presenting the appropriate symptoms. The level of respiratory distress acted out by you and the degree of presentation of pain at injury sites must be consistent for all candidates. As the candidate progresses with the examination, be aware of any period in which he/she touches a simulated injured area. If the scenario indicates that you are to respond with deep painful stimuli and the candidate lightly touches the area, do not respond. Only respond according to the situation as you feel a real victim would in a multiple trauma situation. Do not give the candidate any clues while you are acting as a victim. For example, it is inappropriate to moan that your wrist hurts after you become aware that the candidate has not found that injury. Please remember what areas have been assessed and treated because we may need to discuss the candidate's performance after he/she leaves the room.

The station examiner may use information provided by the trained and well coached victim as data in determining the awarding of points for specific steps on the exam sheets.

Instructions to the Candidate

This station is designed to test your ability to perform a patient assessment of a victim of multi-systems trauma and "voice" treats all conditions and injuries discovered. You must conduct your assessment as you would in the field including communicating with your patient. You may remove the patient's clothing down to shorts or swimsuit if you feel it is necessary. As you conduct your assessment, you should state everything you are assessing. Clinical information not obtainable by visual or physical inspection will be given to you after you demonstrate how you would normally gain that information. You may assume that you have two EMTs working with you and that they are correctly carrying out the verbal treatments you indicate. You have (10) ten minutes to complete this station. Do you have any questions?

Sample Trauma Scenario

The following is an example of an acceptable scenario for this station; however, you will use one of the pre-approved scenarios supplied by IDHS.

TRAUMA SITUATION #1 – PATIENT ASSESSMENT/MANAGEMENT

Mechanism of Injury

You are called to the scene of a motor vehicle crash where you find a victim who was thrown from the car. You find severe damage to the front end of the car. The victim is found lying in a field 30 feet from the upright car.

Injuries

The patient will present with the following injuries. All injuries will be moulaged. Each examiner should program the patient to respond appropriately throughout the assessment and assure the victim has read the "Instructions to Simulated Trauma Victim" that have been provided.

Unresponsive

Left side flail chest

Decreased breath sounds, left side

Cool, clammy skin; no distal pulses

Distended abdomen

Pupils equal

Neck veins flat

Pelvis stable

Open injury of the left femur with capillary bleeding

Vital Signs:

Initial: B/P 72/60, P140, RR 26

Upon recheck: B/P 64/48, P 138, RR 44

PSYCHOMOTOR EXAM GUIDELINES –Medical

Instructions to the Evaluator

This station is designed to test the candidate's ability to use appropriate questioning techniques to assess a patient with a chief complaint of a medical nature and to verbalize appropriate interventions based on the assessment findings. This is a scenario based station and will require extensive dialogue between the examiner and the candidate. A simulated medical patient will answer the questions asked by the candidate based on the scenario being utilized. The candidate will be required to accomplish all assessment steps listed on the exam sheet; however, interventions may be spoken instead of physically accomplished. You must establish a dialogue with the candidate throughout this station. Any information pertaining to sight, sound, touch, or smell that cannot be seen but would be evident immediately in a real patient encounter, must be supplied by the examiner.

The scenario should provide enough information to enable the candidate to form a general impression of the patient's condition. Alert patients should perform as indicated in the scenario. The medical condition of the patient will vary depending upon the scenario utilized in the station. It is essential that once a scenario is established for a specific test station, it remains the same for all candidates being tested at that station.

This station requires the presence of a simulated medical patient. You, or the simulated medical patient, should not alter the patient information provided in the scenario and should provide only the information that is specifically asked for by the candidate. Information pertaining to vital signs should not be provided until the candidate actually performs the steps necessary to gain such information. In order to verify that the simulated patient is familiar with his/her role during the examination, you should ensure he/she reads the "Instructions to the Simulated Medical Patient" provided at the end of this essay. You should also role play the selected scenario with him/her prior to the first candidate entering the station.

The scene size-up should be accomplished once the candidate enters the testing station. Brief questions such as "Is the scene safe?" should be asked by the candidate. When the candidate attempts to determine the nature of the illness, you should respond based on the scenario being utilized, i.e.: Respiratory, Cardiac, Altered Mental Status, Poisoning/Overdose, Environmental Emergency or Obstetrics.

For the purpose of this station, there should be only one patient, no additional help is available and cervical spine stabilization is not indicated. The candidate must verbalize the general impression of the

patient after hearing the scenario. The remainder of the possible points relative to the initial assessment and the focused history and physical examination are listed in the individual scenarios.

The point for "Interventions" should be awarded based on the candidate's ability to verbalize appropriate treatment for the medical emergency described in the scenario.

The candidate must assess signs and symptoms during the focused history by asking appropriate questions. Proposed questions have been listed for seven (7) common responses as a guide. For a candidate to receive the all the points for signs and symptoms, the candidate must ask a minimum of four (4) questions related to the signs and symptoms for patient's chief complaint. The candidate may provide questions on their own as long as the questions are pertinent and related to the chief complaint of the scenario. You should record the number of pertinent questions the candidate asked on the evaluation form.

Failure to address or ask a single question relating to the signs and symptoms constitutes a Critical Criteria under "Did not ask any questions about the present illness." Award a zero (0) in the Signs and Symptoms box and check the "Critical Criteria."

Each candidate is required to complete a full patient assessment. The candidate choosing to transport the victim immediately after the initial assessment must be instructed to continue the focused history and physical examination and ongoing assessment enroute to the hospital.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Simulated Medical Patient

Note: In order to ensure a fair examination environment for each candidate, the simulated victim should be of average height and weight for the scenario being used. For example, the use of very small children is discouraged in this station unless the scenario specifically indicates a pediatric patient.

The following should be reviewed by the station examiner with the person serving as patient.

The examination today will require you to role play a patient experiencing an acute medical emergency. You should act as an actual patient would in the real situation. You must answer the candidate's questions using only the information contained in the scenario provided to you by the examiner for this station. Do not overact or add signs or symptoms to the scenario provided. It is important that you be very familiar with the scenario and the required patient responses. When serving as a patient for the scenario today make every attempt to be consistent with every candidate in presenting the appropriate symptoms. The level of responsiveness, anxiety, respiratory distress, etc., acted out by you must be consistent for all candidates. Do not give the candidate any clues while you are acting as a victim. For example, it is inappropriate to say "I am allergic to penicillin" after you become aware that the candidate has not remembered to ask that question during the SAMPLE history. Please remember what questions you have answered and what areas have been assessed because they may need to be discussed after the candidate leaves the room.

The station examiner may use information provided by the trained and well coached victim as data in determining the awarding of points for specific steps in the exam sheets.

Instructions to the Candidate

This station is designed to test your ability to perform patient assessment of a patient with a chief complaint of a medical nature and "voice" treat all conditions discovered. You must conduct your assessment as you would in the field including communicating with your patient. As you conduct your assessment, you should state everything you are assessing. Clinical information not obtainable by visual or physical inspection will be given to you after you demonstrate how you would normally gain that information. You may assume that you have two (2) EMT's working with you and that they are correctly carrying out the verbal treatments you indicate. You have (10) ten minutes to complete this station. Do you have any questions?

Sample Medical Scenarios

RESPIRATORY

You arrive at a home and find an elderly male patient who is receiving oxygen through a nasal cannula. The patient is 65 years old and appears overweight. He is sitting in a chair in a "tripod" position. You see rapid respirations and there is cyanosis around his lips, fingers and capillary beds.

INITIAL ASSESSMENT

Chief Complaint:	"I'm having hard time breathing and I need to go to the hospital."
Apparent Life Threats:	Respiratory compromise.
Level of Responsiveness:	Patient is only able to speak in short sentences interrupted by coughing.
Airway:	Patent
Breathing:	28 and deep, through pursed lips

Circulation:	No bleeding, pulse rate 120 and strong. There is cyanosis around the lips, fingers and capillary beds
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Onset	"I've had emphysema for the past ten years, but my breathing has been getting worse the past couple of days."
Provokes	"Whenever I go up or down steps, it gets really bad."
Quality	"I don't have any pain; I'm just worried because it is so hard to breath. I can't seem to catch my breath"
Radiate	"I don't have any pain."
Severity	"I can't stop coughing. I think I'm dying."
Time	"I woke up about three hours ago. I haven't been able to breathe right since then."
Interventions	"I turned up the flow of my oxygen about an hour ago."
Allergies	Penicillin and bee stings
Medications	Oxygen and a hand held inhaler
Past Medical History	Treated for emphysema for past 10 years
Last Meal	"I ate breakfast this morning.
Events Leading to Illness	"I got worse a couple of days ago. The day it got really cold and rained all day. Today, I've just felt bad since I got out of bed.
Focused physical examination	Auscultate breath sounds.
Vitals	RR 28, P 120, BP 140/88

CARDIAC

You arrive on the scene where a 57 year old man is complaining of chest pain. He is pale and sweaty.

INITIAL ASSESSMENT

Chief Complaint:	"My chest really hurts. I have angina but this pain is worse than any I have ever felt before."
Apparent Life Threats:	Cardiac compromise
Level of Responsiveness:	Awake and alert
Airway:	Patent
Breathing:	24 and shallow
Circulation:	No bleeding, pulse rate 124 and weak, skin cool and clammy.
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Onset	"The pain woke me up from my afternoon nap"
Provokes	"It hurts really bad and nothing I do makes the pain go away."
Quality	"It started out like indigestion but has gotten a lot worse. It feels like a big weight is pressing against my chest. It makes it hard to breath."
Radiate	"My shoulders and jaws started hurting about ten minutes before you got here, but the worse pain is in the middle of my chest. That's why I called you."
Severity	"This is the worst pain I have ever felt. I can't stand it."
Time	"I've had this pain for about an hour, but it seems like days."

Interventions	"I took my nitroglycerin about 15 minutes ago but it didn't make any difference. Nitro always worked before. Am I having a heart attack?"
Allergies	None
Medications	Nitroglycerin
Past Medical History	Diagnosed with angina two years ago
Last Meal	"I had soup and a sandwich about three hours ago."
Events Leading to Illness	"I was just sleeping when the pain woke me up."
Focused physical examination	Assessment baseline vital signs.
Vitals	RR 24, P 124, BP 144/92

ALTERED MENTAL STATUS

When you arrive on the scene you are met by a 37 year old male who says his wife is a diabetic and isn't acting normal.

INITIAL ASSESSMENT

Chief Complaint:	"My wife just isn't acting right. I can't get her to stay awake. She only opens her eyes then goes right back to sleep."
Apparent Life Threats:	Depressed central nervous system, respiratory compromise
Level of Responsiveness:	Opens eyes in response to being shaken
Airway:	Patent
Breathing:	14 and shallow
Circulation:	120 and weak
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Description of Episode	"My wife took her insulin this morning like any other morning but she has had the flu and has been vomiting."
Onset	"It happened so quickly. She was just talking to me and then she just went to sleep. I haven't really been able to wake her up since."
Duration	"She's been this way for about 15 minutes now. I called you right away. I was really scared."
Associated symptoms	"The only thing that I can think of is that she was vomiting last night and this morning."
Evidence of trauma	"She didn't fall. She was just sitting on the couch and fell asleep. I haven't tried to move her."
Interventions	"I haven't done anything but call you guys. I know she took her insulin this morning."
Seizures	None
Fever	Low grade fever
Allergies	Penicillin
Medications	Insulin
Past Medical History	Insulin dependent diabetic since 21 years of age
Last Meal	"My wife ate breakfast this morning."
Events Leading to Illness	"My wife has had the flu and been vomiting for the past 24 hours."
Focused physical examination	Rapid assessment to rule out trauma
Vitals	RR 14, P 120, BP 110/72.

ALLERGIC REACTION

You have arrived to find a 37 year old male who reports eating cookies he purchased at a bake sale. He has audible wheezing, and is scratching red, blotchy areas on his abdomen, chest and arms.

INITIAL ASSESSMENT

Chief Complaint:	"I'm having an allergic reaction to those cookies I ate."
Apparent Life Threats:	Respiratory and circulatory compromise
Level of Responsiveness:	Awake, very anxious and restless
Airway:	Patent
Breathing:	26, wheezing and deep
Circulation:	No bleeding, pulse 120 and weak, cold and clammy skin
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

History of allergies	"Yes I'm allergic to peanuts."
When ingested	"I ate cookies about 20 minutes ago and began itching all over about five minutes later."
How much ingested	"I only ate two cookies"
Effects	"I'm having trouble breathing and I feel lightheaded and dizzy."

Progression	"My wheezing is worse. Now I'm sweating really badly."
Interventions	"I have my epi-pen upstairs but I'm afraid to stick myself."
Allergies	Peanuts and penicillin
Medications	None
Past Medical History	"I had to spend two days in the hospital the last time this happened."
Last Meal	"The last thing I ate was those cookies."
Events Leading to Illness	"None, except I ate those cookies."
Focused physical examination	Not indicated (award point)
Vitals	RR 26 P 120, BP 90/60

POISONING/OVERDOSE

You arrive on the scene where a 3 year old girl is sitting on her mother's lap. The child appears very sleepy and doesn't look at you as you approach.

INITIAL ASSESSMENT

Chief Complaint:	"I think my baby has swallowed some of my sleeping pills. Please don't let her die!"
Apparent Life Threats:	Depressed central nervous system, respiratory compromise
Level of Responsiveness:	Responds slowly to verbal commands
Airway:	Patent
Breathing:	18 and deep
Circulation:	120 and strong
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Substance	"My baby took my sleeping pills. I don't know what kind they are. They just help me sleep at night."
When ingested	"I think she must have got them about an hour ago when I was in the shower. Her older sister was supposed to be watching her."
How much ingested	"My prescription was almost empty. There couldn't have been more than four of five pills left. Now they're all gone. Please do something."
Effects	"She just isn't acting like herself. She's usually running around and getting into everything."
Progression	"She just seems to get sleepier and sleepier by the minute."
Interventions	"I didn't know what to do, so I just called you. Can't you do something for her?"
Allergies	None
Medications	None
Past Medical History	None
Last Meal	"She ate breakfast this morning."
Events Leading to Illness	"She just swallowed the pills."
Focused physical examination	Completes a rapid trauma assessment to rule out trauma
Vitals	RR 18, P 120, BP 90/64

ENVIRONMENTAL EMERGENCIES

You arrive on the scene as rescuers are pulling a 16 year old female from an ice covered creek. The teenager has been moved out of the creek onto dry land, is completely soaked and appears drowsy.

INITIAL ASSESSMENT

Chief Complaint:	"I saw something in the water below the ice. When I tried to get it out, the ice broke."
Apparent Life Threats:	Generalized hypothermia
Level of Responsiveness:	Responsive, but slow to speak
Airway:	Patent
Breathing:	26 and shallow
Circulation:	No bleeding; pulse 110 and strong; pale, wet skin still covered in wet clothing.
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Source	"I fell in the creek when the ice broke. I tried to get out but the current was to strong. Thank God you came."
Environment	"The water was up to my neck. I could stand up, but I couldn't get out of the water."
Duration	"I think I was in the water for ten minutes before they pulled me out. It felt like an hour."
Loss of consciousness	"I feel sick, but I never passed out."
Effects	Lowered body temperature, slow speech patterns, "I can't stop shivering."

Allergies	None
Medications	None
Past Medical History	None
Last Meal	"I ate lunch at school three hours ago."
Events Leading to Illness	"I thought the ice would hold me."
Focused physical examination	Completes a rapid assessment to rule out trauma
Vitals	RR 26, P 110, BP 120/80

OBSTETRICS

You arrive on the scene where a 26 year old female is laying on the couch saying. "The baby is coming and the pain is killing me!"

INITIAL ASSESSMENT

Chief Complaint:	"I'm nine months pregnant and the baby is coming soon."
Apparent Life Threats:	None
Level of Responsiveness:	Awake and alert
Airway:	Patent
Breathing:	Panting, rapid breathing during contractions
Circulation:	No bleeding, pulse 120, skin is pale
Transport Decision:	Unknown

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Are you Pregnant	See chief complaint (award point if mentioned in general impression)

How long pregnant	See chief complaint (award point if mentioned in general impression).
Pain or contractions	"My pains are every 2-3 minutes and it lasts 2-3 minutes."
Bleeding or discharge	None
Do you feel the need to push	"Yes, every time the pain begins."
Crowning	Present (award point if identified in focused physical exam).
Allergies	None
Medications	None
Past Medical History	"This is my third baby."
Last Meal	"I ate breakfast today."
Events Leading to Illness	"The contractions started a few hours ago and have not stopped."
Focused physical examination	Assess for crowning, bleeding and discharge.
Vitals	RR 40 during contractions, P 120, BP 140/80

PSYCHOMOTOR EXAM GUIDELINES -Cardiac Arrest Management/AED

Instructions to the Evaluator

This station is designed to test the candidate's ability to effectively manage a pre-hospital cardiac arrest by integrating CPR skills, defibrillation, airway adjuncts, and patient/scene management skills. This includes the integration of people and equipment commonly associated with an ambulance responding to a cardiac arrest scene in a basic life support scenario. The candidate will arrive at the scene and encounter an unresponsive patient. A first responder is arriving at the same time as the candidate. The candidate will be required to make appropriate assessments, utilize an automated external defibrillator and correctly manage the patient.

The current American Red Cross and American Heart Association CPR courses instruct candidates in the techniques of CPR, however, they do not instruct the candidate in the use and integration of adjunctive equipment or how to prepare the patient for transportation as he/she will be required to do in an actual field situation. This station tests the candidate's ability to integrate CPR skills into cardiac arrest scene management and the use of the AED.

The candidate must demonstrate effective history gathering skills by obtaining information about the events leading up to, and during, the event. When gathering the history the candidate must ask, at minimum, the following questions:

How long has the victim been down?

Has CPR been done?

When asked these questions, you should answer that the "victim has been in cardiac arrest for an unknown amount of time and that bystander CPR has been in progress for greater than two minutes."

Although gathering a history on the cardiac arrest event is an assessment item, it should not be construed that it overrides the need for resuscitation. The current standards for CPR should be adhered to at all times during this station. The candidate must assess for the presence of a spontaneous pulse and be informed, by you, that there is no spontaneous pulse. The candidate must direct the resumption of CPR by the assistant EMT or the first responder while he/she prepares the defibrillator for use. You should inform the candidate that there is "no pulse" on any pulse check.

The candidate must direct the EMT assistant and the first responder to initiate two (2) rescuers CPR. The candidate should gather additional information from bystanders about the events leading to the cardiac arrest. When asked questions about the event, you should indicate that **"bystanders did not see the victim collapse and are unaware of any associated medical problems."**

The candidate must integrate the use of an oropharyngeal airway and ventilation adjunct into CPR scenario that is already in progress. The candidate voices that he/she would measure and insert the oropharyngeal airway. He/she than must ventilate or direct the ventilation of the patient using adjunctive equipment. Interruption of CPR should not exceed 30 seconds for measuring and placing the airway. The candidate may choose to use a pocket mask, flow restricted oxygen powered ventilation device or bag-valve mask device to ventilate the patient.

You should not indicate displeasure with the candidate's choice of ventilator adjunct since this station is testing the candidate's ability to integrate adjunctive equipment in to a cardiac arrest scene and not local protocols or variations in equipment. Regardless of the device chosen, it is essential that the candidate connect it to supplemental high flow oxygen. After establishing ventilation using the adjunctive equipment the candidate then must re-evaluate the patient, determine the absence of a pulse and repeat the defibrillation sequence. **You should inform the candidate that there is "no pulse" on any pulse check.**

The candidate is required to verbalize appropriate transportation of the patient.

This station requires the presence of an EMT assistant (the examiner may act as the EMT assistant), a first responder, and a defibrillation mannequin. Candidates are to be tested individually with the EMT assistant and the first responder acting as an assistant who provides no input in the application of skills or equipment. The EMT assistant and first responder should be told not to speak but to follow the commands of the candidate. Errors of omission or commission by the first responder cannot result in failure of the candidate unless they were improperly instructed by the candidate.

Due to the extra individuals involved in this station, it is essential that you observe the actions of the candidate at all times. Do not be distracted by the actions of the first responder or the EMT assistant because he should do only as instructed by the candidate. As you observe the candidate ventilating the patient, remember that the ability to ventilate the patient with adequate volumes of air is not being evaluated. Adequate ventilation of a mannequin is evaluated in the "Non Visualized Airway". You are evaluating scene/situation control, integration skills, and decision making ability.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to manage a pre-hospital cardiac arrest by integrating CPR skills, defibrillation, airway adjuncts and patient/scene management skills. There will be an assistant in this station. The assistant will only do as you instruct him/her. You will be dispatched to an unconscious patient at a factory. A first responder will be present and performing CPR. You must immediately establish control of the scene and begin management of the situation. You will have, and be expected to use an automated external defibrillator. At the appropriate time, the patient's airway must be controlled and you must ventilate or direct the ventilation of the patient using adjunctive equipment. You may use any of the supplies available in this room.

You have ten (10) minutes to complete this station.

Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -BLS Airway Management

Instructions to the Evaluator

This station is designed to test the candidate's ability to effectively evaluate, initiate, and continue the proper basic life support airway management and ventilation of an apneic patient using a bag-valve-mask device, suctioning the airway, placing an oropharyngeal airway, and properly inserting a non visualized airway. The candidate will enter the station and find an unresponsive and apneic patient with a palpable central pulse after determining responsiveness. The patient is to be considered a non-traumatic patient for the purposes of this station.

The candidate must initially check the manikin for responsiveness, breathing, and a pulse for a period of five to ten (5-10) seconds. The examiner must inform the candidate that "the patient is apneic and unresponsive" after the candidate demonstrates acceptable technique for establishing unresponsiveness. The examiner must inform the candidate that "you palpate a weak carotid pulse of 60" after the candidate has properly assessed the presence of a pulse. The examiner must inform the candidate that "the mouth is full of secretions and vomitus" after the candidate has either opened the airway manually or if the candidate visualizes the oropharynx area of the mouth. The candidate must demonstrate acceptable suctioning technique before attempting to ventilate the manikin or simulated patient manikin. After the candidate has properly demonstrated an acceptable suctioning technique, the examiner should state that "the mouth and oropharynx are now clear". The candidate should re-open the airway and insert a properly sized OP airway into the oropharynx. If the candidate inserts the airway in an acceptable manner into the manikin, the examiner must inform the candidate that "no gag reflex is present and the patient accepts the airway without difficulty". The candidate must immediately open the manikin or simulated patient's airway and initiate ventilation using an appropriate BVM device within thirty (30) seconds. The candidate may initially voice the attachment or attach the high flow oxygen to the BVM device prior to the initial ventilations; however, the attachment of the oxygen to the BVM device must not delay the initiation of ventilations greater than 30 seconds.

The successful completion of this station **requires** the candidate must initiate high-flow oxygen during the station scenario. If the candidate chooses to initially attach high flow oxygen before beginning their first ventilation, the candidate should not be penalized unless that action delays the initial ventilation for greater than 30 seconds, which would be a Critical Criteria. The candidate must either voice the attachment of high flow oxygen or physically attach the oxygen to the BVM device at some point in the station scenario.

When ventilating the manikin, the candidate must provide a minimum breath to make the chest rise and fall adequately. This ventilation should equal the current standards established for appropriate rescue breathing volumes during basic and advanced life support. This may be validated by observing the rise and fall of the chest during ventilation. If unable to observe rise and fall of the chest on your mannequin, please see examination site coordinator for assistance.

If the candidate begins ventilation using a mouth-to-mouth technique, you should advise the candidate that he is required to use a bag-valve-mask device for all ventilations in this station. After the candidate completes the initial 30 seconds of ventilations, the examiner should advise or inform the candidate that the simulated patient manikin is being performed without difficulty and that a non-visualized airway should be inserted by the candidate. The station examiner or assistant should take over the ventilation for the candidate while the candidate assembles and test the equipment prior to insertion of the device. The candidate should direct the assistant or examiner to pre-oxygenate the patient at a rate of 10-20 breaths per minute. The candidate must insert the non-visualized airway device in an acceptable manner within three attempts and within the ten minute time period for completion of the station. If the candidate fails to complete the insertion of the device on the first attempt, the examiner should monitor the time delay to ascertain if a time delay of thirty seconds is exceeded before ventilations are resumed. The candidate must confirm the placement of the device after insertion ventilating the manikin and observing for chest rise and fall and auscultation of the lung fields and epigastrium.

The examiner must recognize that regional medical control may stipulate the type of supraglottic or non-visualized airway device taught in the class. The examiner should be familiar with the various types of airways (Combi-tube, LMA, King Airway, etc.) potentially utilized with the class.

The station examiner should review all of the Critical Criteria prior to testing the first candidate. Identified critical criteria assess the candidate's performance in the psychomotor and affective domains of learning. This station requires the proper integration by the candidate of his/her assessment skills, time management skills, evaluation skills, and various device insertion skills to successfully complete this station.

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Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

ALTERNATIVE SCENARIOS FOR NVA

Option #1 "If a single tube non-visualized airway is used for testing, then there should be successful ventilations when the device is properly placed. If a Combi-tube is used for testing, the Site Coordinator and the State Representative with the station evaluator should decide whether the initial Combi-tube placement is esophageal (resulting in successful ventilations with the first or blue tube) or tracheal (resulting in the need to use the second or white tube). This decision should be reached prior to testing the first candidate and all candidates should be tested accordingly."

Option #2 "If a single tube non-visualized airway is used for testing, then there should be successful ventilations when the device is properly placed. If the Combi-tube is used for testing, then the testing should be conducted as below:

Even numbered test date: The initial Combi-tube placement is esophageal (resulting in successful ventilations with the first or blue tube).

Odd numbered test date: The initial Combi-tube placement is tracheal (resulting in the need to use the second or white tube) for successful breath sounds and absent epigastric sounds.

Instructions to the Candidate

This station requires the proper integration by the candidate of his/her assessment skills, time management skills, evaluation skills, and various device insertion skills to successfully complete this station. This station is designed to test your ability to assess initial responsiveness, assess and manage an airway utilizing appropriate techniques, ventilate a patient using a bag-valve-mask, and inserting a non visualized airway.

As you enter the station, you will find an apparent unresponsive patient. There are no bystanders and artificial ventilation has not been initiated. Patient management required for completion of this station is complete airway management, proper ventilatory support with the bag-valve-mask, and the proper insertion of the non-visualized airway. You must initially ventilate the patient for a minimum of 30 seconds. You will be evaluated on the appropriateness of ventilator volumes.

I will then inform you that a second rescuer has arrived to assist you with ventilations. Medical control will then advise you to provide the patient with a secured airway by using the non visualized airway. You may use only the equipment available in this room. You will have ten (10) minutes to complete this station.

Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Spinal Immobilization Seated

Instructions to the Evaluator

This station is designed to test the candidate's ability to provide spinal immobilization on a patient using a short spine immobilization device. The candidate will be advised that the scene size-up, initial assessment and focused assessment have been completed and no condition requiring further resuscitation or urgent transportation are present. The patient will present seated in an armless chair, sitting upright with his/her back loosely touching the back of the chair. The position of the patient should be identical for all candidates.

The candidate will be required to treat the specific, isolated, problem of an unstable spine. Initial and ongoing assessments of the patient's airway, breathing and central circulation are not required in this testing station. The candidate will be required to check motor, sensory and circulatory function in each extremity at the proper times throughout this station. Once the candidate has immobilized the seated victim to the half spine device, ask the candidate to explain all key steps he/she would complete while moving the patient to the long backboard. The candidate may check motor, sensory and circulatory function at anytime during the procedure without a loss of points. However, in order to avoid the Critical Criteria, the candidate must check motor, sensory, and circulatory function both before and after immobilization to the device.

If he/she fails to check motor, sensory or circulatory function in all extremities after (verbalizing that the patient is moved to a long backboard), a zero (0) should be placed in the "points awarded" column for that items.

The station instrument was designed to be generic so it could be utilized to evaluate the candidate's performance regardless of the half-spine immobilization device utilized. All manufacturers' instructions describe various orders in which straps and buckles are to be applied when securing the torso to the immobilization devices. This station is not designed to specifically test each individual device but to "generically" verify a candidate's competence in safely and effectively securing a suspected unstable spine in a seated patient.

Therefore, while the specific order of placing and securing straps and buckles is not critical, **it is imperative** that the patient's head be secured to the half-spine immobilization device only **after** the device has been secured to the torso. This sequential order most defensibly minimizes potential cervical

spine compromise and is the most widely accepted and defended order of application to date regardless of the device used.

A trained assistant will be present in the station to assist the candidate by applying manual in-line stabilization of the head and cervical spine only upon the candidate's command. The assistant must be briefed to follow only the commands of the candidate, as the candidate is responsible for directing the actions of the EMT assistant. When directed, the EMT assistant must maintain manual in-line immobilization as a trained EMT would in the field. No unnecessary movement of the head or other "tricks" should be tolerated and are not meant to be a part of this examination station. However, if the assistant is directed to provide improper care, points on the evaluation form relating to this improper care should be deducted and documented. For example; if the candidate directs the assistant to let go of the head prior to its mechanical immobilization, the candidate has failed to maintain manual neutral in-line immobilization. You must check the related statement under "Critical Criteria" and document your rationale. On the other hand, if the assistant accidentally releases immobilization without an order, you should direct the assistant to again take manual in-line immobilization. Immediately, inform the candidate that this action will not affect his/her evaluation. At no time should you allow the candidate or assistant EMT to perform a procedure that would actually injure the simulated patient

This station requires the presence of a simulated victim. The victim should be briefed on his/her role in this station and act as a calm patient would if this were a real situation. The victim should be an adult of average height and weight. You may use comments from the simulated victim about spinal movement and overall care to assist you with the evaluation process after the candidate completes his/her performance and exits the testing station.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to provide spinal immobilization on a patient using a half-spine immobilization device. You and an EMT assistant arrive on the scene of an automobile crash. The scene is safe and there is only one patient. The assistant EMT has completed the initial assessment and no critical condition requiring intervention was found. For the purpose of this station, the patient's vital signs remain stable. You are required to treat the specific, isolated problem of an unstable spine using a half-spine immobilization device. You are responsible for the direction and subsequent actions of the EMT assistant. Transferring and immobilizing the patient to the long backboard should be accomplished verbally. You have (10) ten minutes to complete this station. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Spinal Immobilization Supine

Instructions to the Evaluator

This station is designed to test the candidate's ability to provide spinal immobilization on a patient using a long spine immobilization device. The candidate will be informed that a scene size-up, initial assessment and focused assessment have been completed and no condition requiring further resuscitation exists. The patient will present in supine, anatomical position. The position of the patient should be identical for all candidates.

The candidate will be required to treat the specific, isolated problem of an unstable spine. Initial and ongoing assessment of airway, breathing, and circulation are not required at this testing station. The candidate will be required to check motor, sensory and circulatory function in each extremity at the proper times throughout this station. If the candidate fails to check motor, sensory and circulatory function, a zero (0) should be placed in the points awarded column for those items.

The candidate must, with the help of 2 assistants, move the patient from the ground onto a long spinal immobilization device. There are various acceptable ways to move a patient from the ground onto a long spinal immobilization device, (i.e. logroll, straddle slide, direct patient lift). You should not advocate one method over any others. All methods should be considered acceptable as long as spinal integrity is not compromised. Regardless of the method used, the EMT assistant should control the head and cervical spine while the candidate and evaluator move the patient on the direction of the candidate.

Immobilization of the lower spine/pelvis in line with the torso is required. Lateral movement of the legs will cause angulations of the lower spine and should be avoided. Additionally, tilting the backboard when the pelvis and upper legs are not secured will ultimately cause movement of the legs and angulations of the spine.

A trained assistant will be present in the station to assist the candidate by applying manual in-line stabilization of the head and cervical spine only upon the candidate's command. The assistant must be briefed to follow only the commands of the candidate, as the candidate is responsible for directing the actions of the EMT assistant. When directed, the EMT assistant must maintain manual in-line immobilization as a trained EMT would in the field. No unnecessary movement of the head or other "tricks" should be tolerated and are not meant to be a part of this examination station. However, if the assistant is directed to provide improper care, points on the evaluation form relating to this improper care should be deducted and documented. For example, if the candidate directs the assistant to let go of the

head prior to its mechanical immobilization, the candidate has failed to maintain manual neutral in-line immobilization. You must check the related statement under "Critical Criteria" and document your rationale. On the other hand, if the assistant accidentally releases immobilization without an order, you should direct the assistant to again take manual in-line immobilization. Immediately, inform the candidate that this action will not affect his/her evaluation. At no time should you allow the candidate or assistant EMT to perform a procedure which would actually injure the simulated patient

This station requires the presence of a simulated victim. The victim should be briefed on his/her role in this station and act as a calm patient would if this were a real situation. The victim should be an adult of average height and weight. You may use comments from the simulated victim about spinal movement and overall care to assist you with the evaluation process after the candidate completes their performance and exits the testing station.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

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Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to provide spinal immobilization on a patient using a long spine immobilization device. You arrive on the scene with an EMT assistant. The assistant has completed the scene size-up as well as the initial assessment and no critical condition was found which would require intervention. For the purpose of this testing station, the patient's vital signs remain stable. You are required to treat the specific problem of an unstable spine using a long spine immobilization device. When moving the patient to the device, you should use the help of the assistant EMT and the evaluator. The assistant should control the head and secure the cervical spine of the patient while you and the evaluator move the patient to the immobilization device. You are responsible for proper direction of the assistant. You may use any equipment available in this room. You have ten (10) minutes to complete this station.

Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Splinting Long Bone

Instructions to the Evaluator

This station is designed to test the candidate's ability to use various splints and splinting materials to properly immobilize specific musculoskeletal injuries. The candidate is tested on his/her ability to properly immobilize a swollen, deformed extremity using a rigid splint. The candidate will be advised that a scene size-up and initial assessment have been completed on the victim and that during the focused assessment a deformity of a long bone was detected. The victim will present with a non-angulated, closed, long bone injury of the upper or lower extremity - specifically an injury of the radius, ulna, tibia, fibula, or humerus. You may choose the extremity, but it should be consistent throughout the testing procedure.

The candidate will then be required to treat the specific, isolated extremity injury. Initial and ongoing assessments of the patient's airway, breathing and central circulation are not required at this testing station. The candidate will be required to assess motor, sensory and circulatory function in the injured extremity prior to applying the splint and after completing the splinting process. Additionally, the use of traction splints, pneumatic splints, and vacuum splints is not permitted and these splints should not be available for use.

The candidate is required to "secure entire injured extremity" after the splint has been applied. There are various methods of accomplishing this particular task. Long bone injuries of the upper extremity may be secured to the torso after a splint is applied. Long bone injuries of the lower extremity may be secured by placing the victim properly on a long spine board or applying a rigid long board splint between the victim's legs and then securing the legs together. Any of these methods should be considered acceptable and points should be awarded accordingly.

When splinting the extremity, the candidate is required to immobilize the associated hand or foot in the position of function.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

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Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to properly immobilize a closed, non-angulated long bone injury. You are required to treat only the specific, isolated injury to the extremity. The scene size-up and initial assessment have been completed and during the focused assessment a closed, non-angulated injury of the _____ (radius, ulna, tibia, fibula, humerus) was detected. Ongoing assessment of the patient's airway, breathing, and central circulation is not necessary. You may use any equipment available in this room. You have (5) five minutes to complete this station. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Splinting Joint

Instructions to the Evaluator

The candidate is tested on his/her ability to properly immobilize a joint injury using a sling and swathe. The candidate will be advised that a scene size-up and initial assessment have been completed and that during the focused assessment a joint injury is detected. The victim will present with the extremity positioned at the side. For an elbow or shoulder, have the patient support the lower arm at a 90 degree angle across his/her chest with the uninjured hand. For a knee, have the patient seated on the ground upright with legs extended forward. For this station, the injured extremity should not be positioned away from the body, behind the body, or any position that could not be immobilized by a simple sling and swathe.

The candidate will be required to treat only the specific, isolated injury. Initial and ongoing assessments of the patient's airway, breathing and central circulation are not required at this testing station. The candidate will be required to check motor, sensory and circulatory function in the injured extremity prior to splint application and after completing the splinting process.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

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Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to properly immobilize a non-complicated joint injury. You are required to treat only the specific, isolated injury. The scene size-up and initial assessment have been accomplished on the victim and during the focused assessment a _____ (elbow, knee, ankle, shoulder) injury was detected. Ongoing assessment of the patient's airway, breathing and central circulation is not necessary. You may use any equipment available in this room. You have (5) five minutes to complete this station. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Traction Splint

Instructions to the Evaluator

The candidate is tested on his/her ability to properly immobilize a mid-shaft femur injury using a traction splint. The candidate will be advised that a scene size-up and initial assessment has been completed and that during a focused assessment a mid-shaft femur injury was detected. The victim will present with a closed, non-angulated, mid-shaft femur injury. The victim will be found laying supine with both legs fully extended. The femur deformity should be an isolated injury with no complicating factors that would concern or distract the candidate.

The candidate will be required to treat only the specific, isolated femur injury. Initial and ongoing assessments of the patient's airway breathing and central circulation are not required at this testing station. The candidate will be required to check motor, sensory and circulatory function in the injured extremity prior to splint application and after completing the splinting process.

There should be various types of traction splints at this testing station--specifically traction splints commonly used in the local EMS system, a bipolar traction splint, and a unipolar traction splint. Carefully note the comments listed on the evaluation form for unipolar versus bipolar splint application.

This requires that an assistant EMT be present during testing. Candidates are to be tested individually. All assisting EMTs should be told not to speak but to follow the commands of the candidate. The candidate is responsible for the conduct of the assisting EMT. If the assisting EMT is instructed to provide improper care, areas on the score sheet relating to that care should be deducted. At no time should you allow the candidate or assisting EMT to perform a procedure that would actually injure the simulated victim.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

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Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to properly immobilize a mid-shaft femur injury with a traction splint. You will have an EMT assistant to help you in the application of the device by applying manual traction when directed to do so. You are required to treat only the specific, isolated injury to the femur. The scene size-up and initial assessment have been accomplished on the victim and during the focused assessment a mid-shaft femur deformity was detected. Ongoing assessment of the patient's airway, breathing, and central circulation is not necessary. You may use any equipment available in this room. You have (10) ten minutes to complete this station. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Bleeding Control/Shock

Instructions to the Evaluator

This station is designed to test the candidate's ability to appropriately treat a life threatening hemorrhage and subsequent hypoperfusion. This station will be scenario based and will require some dialogue between you and the candidate. The candidate will be required to properly treat a life threatening hemorrhage.

The victim will present with an arterial bleed from a severe laceration of the extremity. You will prompt the actions of the candidate at predetermined intervals as indicated on the exam sheet. The candidate will be required to provide the appropriate intervention at each interval when the patient's condition changes. It is essential, due to the purpose of this station, that the patient's condition not deteriorate to a point where CPR would be initiated. This station is not designed to test CPR.

The equipment and supplies needed at this station include field dressings and bandages, a tourniquet, a blanket, an oxygen delivery system (may be a mock-up) and a non-rebreather mask.

Acceptable Practices

While the preference for tourniquet application is to use a commercial tourniquet device, improvised tourniquets are acceptable if properly placed and utilized. Improvised tourniquets should be no less than two inches in width. Triangle bandages and blood pressure cuffs are both acceptable mediums for an improvised tourniquet. If a triangle bandage is used, a torquing device such as a pencil or pen must also be made available. The improvised tourniquet is not properly placed unless the torquing device is also utilized. They should be placed approximately 2 inches above the wound. Once a tourniquet is placed, it should not be removed until the scenario is over. Removal of the tourniquet during the scenario will result in a critical fail under the category "uses or orders dangerous or inappropriate intervention." Successful tourniquet placement occurs when the distal pulse is absent and "bleeding ceases."

Due to the scenario format of this station, you are required to prompt the candidate at various times during the exam. When the bleeding is initially managed with a pressure dressing and bandage, you should inform the candidate that the wound is still bleeding. If the candidate places a second pressure dressing over the first, you should again inform him/her that the wound continues to bleed. After the candidate appropriately applies a tourniquet to control the hemorrhage, you should inform him/her that

the bleeding is controlled. Once the bleeding is controlled, you should indicate to the candidate that the victim is in a hypoperfused state by indicating signs and symptoms appropriate for this level of shock (example: cool clammy skin, restlessness, BP 110/80, P 118, R 30).

Controversy exists in the national EMS community concerning the removal of dressings by EMTs when controlling hemorrhage. This station does not require the EMT to remove any dressing once applied. If the candidate chooses to remove the initial dressing to apply direct finger tip pressure, you should award the point for "**applies an additional dressing to the wound**" since this is an acceptable alternative method to control bleeding when the application of an initial pressure dressing fails to stop the flow of blood.

This station requires the presence of a simulated victim. The victim may be an appropriate mannequin or a live person. If used, the mannequin must be a hard shell and anatomically accurate.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

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Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to control hemorrhage. This is a scenario based testing station. As you progress through the scenario, you will be given various signs and symptoms appropriate for the patient's condition. You will be required to manage the patient based on these signs and symptoms. A scenario will be read aloud to you and you will be given an opportunity to ask clarifying questions about the scenario, however, you will not receive answers to any questions about the actual steps of the procedures to be performed. You may use any of the supplies and equipment available in this room. You have (10) ten minutes to complete this station. Do you have any questions?

Scenario

You respond to a stabbing and find a 25 year old male victim. Upon examination you find a two (2) inch stab wound to the inside of the right arm at the anterior elbow crease (antecubital fascia). Bright red blood is spurting from the wound. The scene is safe and the patient is responsive and alert. His airway is open and he is breathing adequately. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES –Oxygen Preparation and Application

Instructions to the Evaluator

This station is designed to test the candidate's ability to correctly assemble the equipment needed to administer supplemental oxygen in the pre-hospital setting. The candidate will be required to assemble the oxygen delivery system. During this procedure, the candidate must check the tank/regulator for leaks. If a leak is found and not corrected, you should record a '0' in the points awarded column, and check the critical criteria.

The candidate should administer correct oxygen liter flow to a patient using a non-rebreather mask. The candidate will be informed that the patient does not tolerate a non-rebreather mask and will be instructed to administer oxygen using a nasal cannula.

Oxygen liter flow rates are normally established according to the patient history and patient condition. Since this is an isolated skills test, liter flow rates of greater than 12 liters/minute for the non-rebreather and less than six (6) liters/minute for the nasal cannula are acceptable.

The candidate will be required to discontinue oxygen therapy including relieving all pressure from the oxygen tank regulator.

The equipment need at this station includes an oxygen tank, a regulator with a flow meter, a non-rebreather mask, and a nasal cannula. The oxygen tank at this station must be fully pressurized (air or oxygen) and the regulator/flow meter must be functional. The simulated patient for this station may be a live person or mannequin. If a mannequin is used it must have anatomically correct ears, nose and mouth.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

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"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Due to the nature of this station, infection control measures must be enforced.

You should observe the candidate ventilating the mannequin for a period of 30 seconds. During this time you should pay close attention to volumes. If you observe one ventilation error or less in 30 seconds (volume only) you should award one (1) point. No points should be awarded if you observe two or more ventilation errors in 30 seconds.

Instructions to the Candidate

This station is designed to test your ability to correctly assemble the equipment needed to administer supplemental oxygen in the pre-hospital setting. This is an isolated skills test. You will be required to assemble an oxygen tank and a regulator and administer oxygen to a patient using a non-rebreather mask. At this point you will be instructed to discontinue oxygen administration by the non-rebreather mask and

start oxygen administration using a nasal cannula because the patient cannot tolerate the mask. Once you have initiated oxygen administration using a nasal cannula, you will be instructed to discontinue oxygen administration completely. You may use only the equipment available in this room. You have five (5) minutes to complete this station. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES – *Ventilation and Airway Management for Apneic Patient*

Instructions to the Evaluator

This station is designed to test the candidate's ability to effectively ventilate a patient with supplemental oxygen using a bag valve mask technique. The candidate is to be advised that the patient is apneic and has a central pulse. Upon entering the skill station, the candidate with be required to suction the patient and place an oral adjunct appropriately. When ventilating the patient the candidate must provide adequate volume per breath, this should produce visible rise and fall of the chest.

This station requires a mannequin that is capable of being ventilated so that the evaluator can observe the chest rise and call with each ventilation. The equipment need at this station includes an oxygen tank, a regulator with a flow meter, rigid suctioning device, OP airway and a bag valve mask with appropriate mask (adult size) and tubing. The oxygen tank at this station must be fully pressurized (air or oxygen) and the regulator/flow meter must be functional.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

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"Failure to manage the patient as a competent EMT"

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For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

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You should observe the candidate ventilating the mannequin for a period of 30 seconds. During this time you should pay close attention to volumes. If you observe one ventilation error or less in 30 seconds (volume only) you should award one (1) point. No points should be awarded if you observe two or more ventilation errors in 30 seconds.

Instructions to the Candidate

Ventilation and Airway Management for Apneic Patient

This station is designed to test your ability to effectively ventilate a patient with supplemental oxygen using a bag valve mask technique. The patient management required is suctioning of the patient, placement of an oral adjunct and ventilatory support using a bag valve mask technique with supplemental oxygen. You must ventilate the patient for at least 30 seconds. You will be evaluated on the appropriateness of ventilatory volumes. You may use any equipment available in this room. You have five (5) minutes to complete this station.

Do you have any questions?

Attachment #5

APPLICATION FOR WAIVER OF EMS COMMISSION RULES (836 IAC)

State Form 54693 (5-11)

INSTRUCTIONS: Please complete all sections of this form. Please make your answers specific. You may attach any additional supporting documentation needed to support your application.

APPLICANT INFORMATION

Name of applicant (Person who would be in violation, if the waiver is not granted.)	Title	PSID or Provider number
Parke and Vermillion County Ambulances		P-0111 V-0818

Telephone number	Other telephone number	E-mail address
(812) 237-8698	(812) 237-3121	apowell@uhhg.org

Name of organization, if applicable	Type
Union Hospitals Richard G. Lugar for Rural Health	☐ Training Institution ☑ Provider

Address *(number and street, city, state, and ZIP code)*

1433 N. 6 1/2 Street Terre Haute, Indiana 47807

Has the Preparedness and Training Division issued a violation order?
☐ Yes ☑ No

If yes, attach a copy of the order.

DESCRIPTION OF REQUESTED WAIVER

List the specific commission rule (836 IAC number).

8361AC 4-4(e) (1) (A), 8361AC 4-4 (e) (1) (B)

Nature of non-compliance (how you do not comply with the rule)

Respectfully request that the EMS Commissioners re-evaluate the Basic Life Support pilot program whereby the providers are acquiring and transmitting electrocardiograms through the utilization of the pateint assisted device. We are prepared to submit 2 years of findings for reveiw by the commision. We are currently functioning under a year three approval through the IU- IRB that will expire in March of 2015.

DEMONSTRATION THAT PUBLIC HEALTH, SAFETY, AND WELFARE WILL BE PROTECTED

Select the most appropriate statement below:

☑ Non-compliance with the rule will not jeopardize the quality of patient care.
☐ Applicant will undertake alternative actions in lieu of compliance with the rule to ensure that granting the waiver will not jeopardize the quality of patient care. Explain why alternative actions would be adequate *(be specific)*.

Facts demonstrating that the above selected statement is true:

The EMS Commission supported theproject to investigate rural and remote alternatives for ambulances that are Basic and/ or Advanced EMS service. The Parke and Vermillion BLS EKG waiver was originally presented to the EMS Commission on January 19, 2012. At that time it was supported Dr. Olinger with the condition that an IRB would be providing oversight. In light of the changes to the current provider skills levels we are requesting a ruling by the EMS Commision regarding these findings (attached).

STATEMENT OF UNDUE HARDSHIP

836 IAC 1-1-3(b) allows the Commission to waive any rule that imposes an undue hardship on the person (except rules that sets forth educational standards).

Facts demonstrating that compliance with the rule creates an undue hardship:

SIGNATURE

Signature of applicant	Printed name of applicant	Date *(month, day, year)*
	Angela M Powell	5/5/2014

APPLICATION FOR WAIVER OF EMS COMMISSION RULES (836 IAC)

State Form 54693 (5-11)

INSTRUCTIONS: Please complete all sections of this form Please make your answers specific. You may attach any additional supporting documentation needed to support your application.

APPLICANT INFORMATION

Name of applicant (Person who would be in violation, if the waiver is not granted.)	Title	PSID or Provider number
Parke and Vermillion County Ambulances		P-0111 V-0818

Telephone number	Other telephone number	E-mail address
(812) 230-3362	(812) 237-8698	apowell@uhhg.org

Name of organization, if applicable	Type
Union Hospital's Richard G. Lugar Center for Rural Health	☐ Training Institution ☑ Provider

Address *(number and street, city, state, and ZIP code)*

1433 N 6-1/2 Street, Terre Haute, IN 47807

Has the Preparedness and Training Division issued a violation order?	
☐ Yes ☑ No	*If yes, attach a copy of the order.*

DESCRIPTION OF REQUESTED WAIVER

List the specific commission rule (836 IAC number).

8361AC 4-4-1(e) (1) (A), 8361AC 4-4-1 (e) (1) (B)

Nature of non-compliance (how you do not comply with the rule)

Request a 6 month extension regarding the waiver to enable basic life support and advanced life support providers to acquire and transmit 12 lead EKG's through the use of a patient assisted 12 lead device for completion of study data reporting to IRB, and EMS Commission . This waiver will allow the submission of the 1 year data collection period approved by the Indiana University- IRB March 16, 2012- March 14, 2013 (Attached - Document A)

DEMONSTRATION THAT PUBLIC HEALTH, SAFETY, AND WELFARE WILL BE PROTECTED

Select the most appropriate statement below:

☑ Non-compliance with the rule will not jeopardize the quality of patient care.

☐ Applicant will undertake alternative actions in lieu of compliance with the rule to ensure that granting the waiver will not jeopardize the quality of patient care. Explain why alternative actions would be adequate *(be specific)*.

Facts demonstrating that the above selected statement is true:

The Parke and Vermillion BLS EKG waiver was originally presented to the EMS Commission for consideration on January 19, 2012. With the recommendations of Dr. Michael Olinger the EMS Commission agreed to support the waiver as long as the study was supported by an IRB. The IRB is supported by IU Health with Dr. James Turner as the acting principle investigator. Permission is requested to complete the study and report findings to the EMS Commission is March of 2013.

STATEMENT OF UNDUE HARDSHIP

836 IAC 1-1-3(b) allows the Commission to waive any rule that imposes an undue hardship on the person (except rules that sets forth educational standards).

Facts demonstrating that compliance with the rule creates an undue hardship:

N/A

SIGNATURE

Signature of applicant	Printed name of applicant	Date *(month, day, year)*
	Angela Powell	1/4/2013

INDIANA UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB)

RENEWAL

OPEN TO ENROLLMENT

Reviewing IRB (please choose one): IRB STUDY NUMBER: 1202008019

Biomedical: ☐ IRB-02 ☒ IRB-03 ☐ IRB-04 ☐ IRB-05

Behavioral: ☐ IRB-01 ☐ IUB IRB

Please type only in the gray boxes. To mark a box as checked, double-click the box, select "checked", and click "OK". Please see the Continuing Review/Closeout Form Instructions for more information.

SECTION I: INVESTIGATOR INFORMATION

Principal Investigator:

Name *(Last, First, Middle Initial)*: **James A. Turner, DO**

Department: Assistant Professor CFM Phone: 812-238-7479 E-Mail: jturner@uhhg.org

Additional Study Contacts:

Name: Angela Powell, RN, BSN Phone: 812-238-7479 E-Mail: apowell@uhhg.org

Name: Joe Biggs, PHD Phone: 812-238-7479 E-Mail: BHJRB@uhhg.org

Name: Stephanie Laws, Phone: 812-238-7479 E-Mail: slaws@uhhg.org

Project Title: **Basic Life Support Technician EGK Transmission from Rural Areas**

Funding Source: HRSA - OAT Sponsor Number: #H2ARH20178

Sponsor Type: ☒ Federal ☐ Federal Pass-Through ☐ State ☐ Industry ☐ Not-for-Profit ☐ Unfunded ☐ Internally Funded

Funding Status: ☐ Pending ☒ Funded ☐ N/A

SECTION II: CURRENT STUDY STATUS

☒ **ONGOING – OPEN TO ENROLLMENT**

Date study was initiated: March 16, 2012

Projected date of completion: March 16, 2015

(Select one below)

☒ Enrollment of new participants or review of records/specimens continues

☐ No participants have been enrolled to date. Please explain, then skip to Section V: _____

☐ **Please check here if the study is currently suspended (temporarily) and indicate the reason(s) for the suspension:**

_____

SECTION III: SUBJECT SUMMARY

☒ Check here if your study utilizes records or specimens versus human subjects. When the form asks for the number of subjects, document the number of records/specimens that have been reviewed or collected.

☒ Check here if the IRB has approved a waiver of consent for your study. When the form asks for the number of subjects consented, document the number of records that have been reviewed or the number of individuals enrolled.

1. **Subject Summary Table**

		On-Site
Since last IRB review	Total number of subjects **CONSENTED**	**38**
	Total number of subjects who **FAILED SCREENING** (e.g. found ineligible to participate)	**0**
	Total number of subjects who have **WITHDRAWN** from the study	**0**
Since beginning of study	Total number of subjects **CONSENTED**	**96**
	Total number of subjects who **FAILED SCREENING** (e.g. found ineligible to participate)	**0**
	Total number of subjects who have **WITHDRAWN** from the study	**0**
Number of **ACTIVE** subjects		**96**
Number of subjects who have **COMPLETED** the study		**0**

If necessary, please provide further explanation regarding the subject summary: The subject group is limited to patients that activate Parke and Vermillion County ambulances through the e-911 dispatch centers with a chief complaint of "chest pain" including the following signs and symptoms of coronary syndrome; chest pain, jaw pain, left arm pain, neck pain, nausea, shortness of breath, dizziness and sweating. EMS providers determine eligibility and assist the patient to obtain a 12 lead EKG through the utilization of the non-invasive Physioglove device. All project data is collected through the review of closed medical records including emergency department records, EMS run reports and actual EKGs as saved to secure server.

2. **Withdrawal.** Have any subjects withdrawn from the study since the last IRB review?
   - ☒ No
   - ☐ Yes, state the reasons for withdrawal:_____

Justification for Study Continuation. Have subjects accrued in the study since the last IRB review?
- ☒ Yes
- ☐ No. Justify study continuation:_____

4. **Vulnerable Populations.** Are any of the subjects who have consented or enrolled in the study members of a vulnerable population?
   - ☒ No.
   - ☐ Yes. Has the IRB previously approved enrollment of these subjects? ☐ Yes. Continue to Question 5.
     - ☐ No. **You must submit an amendment to the IRB to request the inclusion of these subjects.** Subjects in the the following vulnerable populations were enrolled without IRB approval.
       - ☐ Children
       - ☐ Prisoners
       - ☐ Cognitively Impaired
       - ☐ Pregnant Women and Human Fetuses
       - ☐ Economically/Educationally Disadvantaged
       - ☐ Students

5. **Short Form Consent.** Were any subjects consented using the short form written consent document?
   - ☒ No.
   - ☐ Yes. Please describe the circumstances of each subject enrolled, including language in which the consent process was conducted:_____
     - ☐ Is there a reasonable possibility that additional subjects who speak this language could be enrolled?
       - ☐ No.
       - ☐ Yes. Please submit a translated version of the IRB-approved consent document for review and approval by the IRB.

6. **For studies employing waivers of assent:**
   a. State the number of assent waivers that were employed since the last IRB review: _____
   b. Explain the circumstances surrounding each assent waiver employed: _____

SECTION IV: ETHNIC/RACIAL REPORTING REQUIRED FOR FEDERALLY-SPONSORED AND VA STUDIES

SUBJECT ACCRUAL				
Ethnic Category	**Sex/Gender**			**Total**
	Females	**Males**	**Unknown or Not Reported**	
Hispanic or Latino				
Not Hispanic or Latino				
Unknown (Individuals Not Reporting Ethnicity)			96	96
Ethnic Category Total of All Subjects*			**96**	**96**
Racial Categories				
American Indian/Alaska Native				
Asian				
Native Hawaiian or Other Pacific Islander				
Black or African American				
White	18	22		**38**
More Than One Race				
Unknown or Not Reported				
Racial Categories Total of All Subjects*	**54**	**44**		**38**

If ETHNIC and RACIAL category totals are not equal, please explain: _____

1. Have there been any unexpected problems recruiting participants, especially subjects in a particular category (including children and women)?
   - ☒ No.
   - ☐ Yes. Please explain: _____

2. **Is this study conducted at, funded by, or recruiting from the VA?**
   - ☒ No.
   - ☐ Yes. In the table below, please indicate the total number of VA subjects enrolled in the study and indicate in which categories those subjects fall and how many represent each category indicated.

Total number of VA subjects: _____

☐	Children:	0
☐	Cognitively Impaired:	0
☐	Economically/Educationally Disadvantaged:	0
☐	Pregnant Women and Fetuses:	0
☐	Prisoners:	0
☐	Students:	0

SECTION V: STUDY SUMMARY OF EVENTS

1. **Since the last IRB review**, did any unanticipated problems, including adverse events, protocol deviations, or subject complaints, or noncompliance occur that required prompt reporting to the IRB?
   - ☒ No.
   - ☐ Yes. Were these events reported previously to the IRB and VA, if applicable?
     - ☐ No. Please explain why these events were not previously reported: _____
     - ☐ Yes. Provide a **summary** of these events: _____
       - ☐ Check here if the **summary** is attached.

2. **Since the last IRB review**, did any protocol-related adverse events, subject complaints, or protocol deviations occur on-site that did **not** require prompt reporting to the IRB?
   - ☒ No.
   - ☐ Yes. Provide a **summary** of these events: _____

☐ Check here if the **summary** is attached.

3. Is there a data safety monitoring plan for this study?
   - ☒ No. This study is minimal risk (exempt or expedited).
   - ☐ Yes. Does the plan include a data safety monitoring board?
     - ☐ No.
     - ☐ Yes. Please provide the most recent monitoring report if it has not already been provided to the IRB or explain why one cannot be provided: _____

4. Based on the above information, do you feel the validity of the data is affected?
   - ☒ No.
   - ☐ Yes. Explain: _____

5. Based on the above information, do you feel there is an increase in risk to subjects or others or in the frequency or severity of adverse events, protocol deviations, problems, complaints, etc. since the last IRB review?
   - ☒ No.
   - ☐ Yes. Explain: _____

SECTION VI: SUMMARY

Describe the progress of the research, including any preliminary observations and information about study results or trends:

If no progress description is provided, please explain why: The Basic Life Support (BLS) electrocardiogram (EKG) transmission study was implemented in the counties of Parke and Vermillion on March 22, 2012. Prior to study implementation all participating EMS providers and emergency department staff received orientation to the BLS EKG study protocol. 15 BLS – Emergency Medical Technicians (EMTs) from Parke and Vermillion counties were educated for participation in the program. Education included protocol review, equipment training, and general education on the identification of heart attacks. All participants were required to return demonstrate individual competency in EKG transmission by completing the acquisition and successful transmission of at least two EKGs during the class. To evaluate the perceptions of EMS staff members regarding the EKG transmission process and equipment all BLS staff completed a 5-question Likert survey immediately following training. A summary of EMS providers responses are provided the table below. In March of 2013 the survey will be re-administered and comparison data will be collected for evaluation.

Questions	1 Strongly Disagree	2 Disagree	3 Neither	4 Agree	5 Strongly Agree
The Toughbook laptop equipment is user friendly				4	9
EKG transmission is useful in the care of chest pain patients				2	13
The Phyioglove is simple to apply				4	9
Patients can easily assist staff with the application of the glove				4	9
EKG transmission is possible without disrupting patient care				6	7
I am confident that I can apply and transmit EKG's within the protocol			1		

In year two of the study 38 patients transported by EMS have met the approved protocol criteria for EKG transmission. The study findings are summarized in the table below. BLS-EMTs have demonstrated their ability to consistently navigate protocol and technology through the successful transmission of EKGs. The Principle Investigator reviews all EKGs to determine diagnostic quality and education is provided to BLS providers as recommended. It should be noted that of the 38 patients in the study there were no patients with the diagnosis of ST – elevation myocardial infarction (STEMI). The **primary** purpose of the study is to evaluate the impact of rural BLS EKG transmission from the field and its ability to impact door-to balloon times on the STEMI population. The researchers are in the process of investigating the causation for this phenomenon. Based on the fact that there have been **no patients with a STEMI diagnosis transported by ambulance in the study counties this year** an extension of the IRB is essential for further investigation and evaluation regarding the impact of rural BLS EKG transmission on cardiac patients with a diagnosis of STEMI.

In addition to the data findings related to rural patient impact and EMS integration this study has provide insight into areas that warrant additional research including: the barriers and challenges of rural EMS as it relates to budgetary restrictions; EMS staffing shortages in rural areas; challenges related to cellular coverage and radio transmission in remote areas; and barriers related to the perceptions of rural populations regarding the early activation of EMS for heart attack care. Implementation of this study protocol has highlighted the impact that pre-hospital care integration has on internal quality improvement and coordination of care for the chest pain patient.

On March 22, 2013 the findings of year one of this study were presented to the Indiana EMS Commission to provide information to assists the members in making a determination regarding the future of BLS provider –and EKG transmission in the state of Indiana.

Since that date the EMS Commission has approved and implemented new guidelines that will go into effect in July of 2014. These new guidelines will allow the EKG transmission by the "basic- advanced" level provider. As of this writing all of the basic level providers are currently enrolled in a "bridge" course to certify them at the next level of EMS service. At the time of the training completion these agencies will be allowed to transmit 12 lead EKGs under their new protocols.

Parke County EMS		Vermillion County EMS	
Total BLS EKG Transmissions	5	Total BLS EKG Transmissions	33
Total Number of Subjects that met criteria for EKG	5	Total Number of Subjects hat met criteria for EKG	33
Total BLS EKG Diagnostic Quality	5	Total BLS EKGs Diagnostic Quality	32
Total BLS Non-Diagnostic Quality	0	Total BLS Non-Diagnostic Quality	1
Total Numbers of Failed Transmissions – Technician	0	Total Numbers of Failed Transmissions – User Error	1
Total Numbers of Failed Transmissions – Technology	1	Total Numbers of Failed Transmissions –Technology	2
Total Number of STEMIs	0	Total Number of STEMIs	0
Average Scene to EKG Time (minutes)	12.2	Average Scene to EKG Time	8.2
Average Acquisition to Transmission Time	7.2	Average Acquisition to Transmission Time	3.2

1. Have subjects experienced any **direct** benefit(s) from their participation in the study?
   - ☐ No.
   - ☒ Yes.

   Please explain: Patients participating in this study receive the additional benefit of having a pre-hospital EKG reviewed by the rural emergency department physician. Pre-hospital EKG evaluation provides crucial information that assists the emergency department team in the accurate triage patients prior to hospital arrival.

2. If any recent literature has been published or presented by you or others since the last IRB review, has it demonstrated a significant impact on the conduct of the study or the well-being of subjects?
   - ☒ N/A. There has not been any recent literature published or presented since the last IRB review.
   - ☐ No.
   - ☐ Yes. Attach a copy or explain: _____

3. Have there been any audits from federal agencies conducted since the last IRB review that identified unanticipated problems involving risks to subjects or others or noncompliance?
   - ☒ No.
   - ☐ Yes. Attach the report(s).

4. Do you believe the risk/benefit ratio has changed based on all of the information provided on this form and any attachments?
   - ☒ No.
   - ☐ Yes. Explain:_____

SECTION VII: CO-INVESTIGATOR UPDATE

☒ This submission does NOT include additions or removals to the Investigator List. *Proceed to section VIII.*

☐ This submission includes additions or removals to the Investigator List. The updated Investigator List is attached.

The following investigators are being added to the current Investigator List:

The following investigators are being **removed** from the Investigator List and will no longer be participating in this research:

SECTION VIII: REQUIRED ATTACHMENTS

All current study documents must be included with your continuing review submission. Please check the appropriate boxes as they apply to your study.

- ☐ Assent, dated: _____
  Number of assent documents: _____
- ☐ Authorization, dated: _____
  Number of authorizations: _____
- ☐ Clinical Investigator's Brochure, dated: _____
- ☐ Drug or Biological Products Form, dated: _____
- ☒ HIPAA & Recruitment Checklist, dated: 2-9-2012
- ☐ Informed Consent, dated: _____
  Number of consent documents: _____
- ☐ Medical Device Form, dated: _____
- ☒ Protocol, dated: _____
- ☐ Recruitment materials (please list and date): _____
- ☐ Request form(s) for vulnerable population(s) (please list and date); _____
- ☒ Surveys, questionnaires (please list and date): EKG Survey
- ☒ Summary Safeguard Statement or HUD Form, dated: 2-10-2012
- ☐ Study Information Sheet
- ☒ Test Articles Supplement, dated: _____
- ☐ Other (please list and date): _____

Include the following documents, as applicable:

- ☐ Publications, if you answered YES to VI.3. above
- ☐ Audit reports, if you answered YES to VI.4 above
- ☐ Summaries, if you indicated in Section V that summaries are attached
- ☐ DSMB report, if the study includes a DSMB and you are submitting the most recent DSMB report
- ☐ Interim findings, if there are any to report
- ☐ Multi-center trial reports, if there are any available

NOTES:

- No changes to previously approved study documents are allowed at the time of continuing review unless requested by the IRB.
- Incomplete submissions will result in a processing delay, which could result in study expiration.
- **VA Requirements**: For studies conducted at the VA, utilizing VA funding or VA patients, you must provide a copy of the approved continuing review form to the VA Research Service office.

SECTION IX: INVESTIGATOR STATEMENT OF COMPLIANCE

By submitting this form, the Principal Investigator assures that all information provided is accurate. He/she assures that procedures performed under this project will be conducted in strict accordance with federal regulations and Indiana University policies and procedures that govern research involving human subjects. He/she acknowledges that he/she has the resources required to conduct research in a way that will protect the rights and welfare of participants, and that he/she will employ sound study design which minimizes risks to subjects. He/she agrees to submit *any* change to the project (e.g. change in principal investigator, research methodology, subject recruitment procedures, etc.) to the Board in the form of an amendment for IRB approval prior to implementation.

Recorded in the Minutes of: _____
_____

SECTION X: IRB APPROVAL

For IU Human Subjects Office Use Only

Type of review: ☐ Full Board
☒ Expedited, Category: 4 & 7 Approved for a period of: ☒ one (1) year ☐ two (2) years

STATUS OF STUDY: ONGOING - Open to Enrollment

This continuing review has been reviewed and approved as meeting the criteria for IRB approval as outlined in 45 CFR 46.111(a) by the Indiana University IRB. Based on the criteria for determining the frequency of continuing review and the level of risk, this study will expire on: _____. If the study is not re-approved prior to that date all research activities must cease on that date, including enrollment of new subjects, intervention/interaction with current participants, and analysis of identified data.

Authorized IRB Signature:_____IRB Approval Date:_____

Printed Name of IRB Member: _____

For IU Human Subjects Office use only.

Recorded in the Minutes of: _____

INDIANA UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB) REVIEW
SUMMARY SAFEGUARD STATEMENT

IRB STUDY NUMBER: 1202008
PRINCIPAL INVESTIGATOR: James A. Turner,
DOCUMENT DATE: February 10, 2

THIS FORM MUST BE NEATLY TYPED. (DO NOT TYPE ON THE REVERSE SIDE OF ANY FORMS). **Note: To chec box on this form, double-click the box and select "Checked" under "Default Value."**

STUDY TITLE: Basic Life Support Technician EKG Transmission from Rural Areas

Please type only in the gray boxes. To mark a box as checked, double-click the box, select "checked", and click "OK".

SECTION I: STUDY DESCRIPTION

Union Hospital's Richard G. Lugar Center for Rural Health, Telemedicine and Innovative Technologies Department, is investigating options for field transmission specifically in relation to door to balloon times and ST Elevation Myocardial Infarction (STEMI) care. This project is a time sensitive grant funded project sponsored by the United States Department Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Office for Advancement of Telehealth (OAT). The project scope is limited to field transmission of EKGs for the care of the acute coronary patient experiencing a STEMI. This project is budget neutral and there are no related Basic Life Support (BLS) level charges or income revenue streams. All equipment purchases will be supported through grant funds. In 2010 the receiving CAH trea a total of 160 chest pain patients in the Emergency Department. Of those patients, 23 (14%) were diagnosed with Acute Myocardial Infarction (AMI), 18 of those 23 patients arrived by ambulance. Implementation of a 12 Lead Electrocardiograph (EKG) program has the ability to impact 160 rural cardiac patients per year, Rapid identification of patients experiencing a STEMI will facilitate prompt treatment for this life threatening diagnosis.

The primary goal of this research project is to gain additional information on the how field transmission of EKG's can impact the door-to-balloon times for rural patients in remote outlying counties in Indiana. Emergency Medical Technicia –Basic (EMT-B) and Emergency Medical Technicians- Advanced (EMT-A) will utilize the patient assisted, Food and Dr Administration (FDA) approved, Physioglove device to obtain and transmit EKG's from the field. Every patient that is treated for a chest pain diagnosis will receive an EKG tracing that will be transmitted to the closest receiving Emergency Department. Early transmission of EKG's will allow for coordination of services through the receiving Emergency Department Physician and prompt activation of the "Code STEMI " process for rapid deployment of the cardiologist and catheterization team.

Does early transmission of patient assisted EKG by BLS (EMT-B and EMT-A) personnel impact door-to-balloon times rural patients? Our hypothesis is that early transmission of the EKG to the local critical access hospital will offer the emergency department staff and the cardiac catheterization team additional minutes to coordinate and prepare for the arriv of the STEMI patient. Currently, rural patients in Parke and Vermillion Counties are transported up to 30 minutes prior to arriving at the local Critical Access Facility (CAH). Treatment at the CAH is coordinated and succinct due to the current i house "Code STEMI" process. The goal door to transfer time for this non- Percutaneous Coronary Intervention (PCI) faci is 25 minutes. Consistent delivery of this goal results in an unwarranted delay to PCI. At the CAH an EKG is obtained and patient care is administered based on these findings. Transportation arrangements such as an Advanced Cardiac Life Supp (ACLS) certified transport nurse and/ or Paramedic transport are arranged at this time. Field transmission of the EKG will allow the CAH staff to initiate ACLS/ Advanced Life Support (ALS) transport and activate the "Code STEMI" team prior the patients' arrival. Early activation will support the rapid deployment of the cardiac catheterization team.

The pilot study is designed to evaluate patient-assisted electrocardiogram (EKG) transmission from the field to the nearest receiving facility for basic and advanced level providers. The pilot study time line is one (1) year from the date of IRB approval. This study applies to patients transported by Parke and Vermillion County Ambulance services only. It is our be that the new technology will provide a standardized method for basic and advanced level providers to acquire and transmi EKG's from the pre-hospital care setting to the CAH prior to the patient's arrival. This process will facilitate rapid notification and coordination of the existing 'Code STEMI" process to ensure consistent PCI access of less than 90 minute from the time of symptom onset.

SECTION II: HIPAA

A. Are you part of a covered entity or are you involving a covered entity in your research? Please review the **Covered Entity Checklist** for guidance.

☐ 1. A recruitment database that includes health or demographic information will be developed and used to identify recruit potential research subjects. NOTE: If you plan to use this research database as a recruitment tool for fu research projects, then a separate research database protocol should be submitted to the IRB for approval.

Please describe:

☐ 2. An existing IRB-approved recruitment database will be used for this project.

Please Provide the IRB # for the approved Recruitment Database Protocol:

☐ 3. An existing research database (i.e. data that was previously collected for research purposes and not patient care) wil used for recruitment for this project.

Please describe:

Submit an Authorization for recruitment for IRB Approval or request a Waiver of Authorization in Section II below.

SECTION III: AUTHORIZATION FOR THE USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ I will be obtaining an authorization for the release of health information for research at the time of enrollment/consent. Please submit a copy of the authorization for review.

☒ I am requesting a waiver of authorization for the release of health information for the following procedures (*check all that app and complete questions 1-3 below*):

- ☒ **Recruitment**. A waiver of authorization for recruitment allows the study team to view potential participants' PHI prior to enrollment in the study in order to determine eligibility, without requiring potential participants to sign a wri authorization.
- ☒ **Participation in the study**. A waiver of authorization for participation allows the study team to utilize, access, collec generate study subjects' PHI without requiring subjects to sign a written authorization.

NOTE: Approval of a waiver of authorization for *recruitment* does not imply approval of a waiver of authorization *participation*. Any waiver of authorization, whether for recruitment or participation, requires you to track the disclosure health information for a period of six years.

Request for a waiver of authorization for the release of health information

1. Explain how this research involves no more than minimal risk of loss of privacy to the subject.

   All chart reviews are completed on closed records by the principle and secondary investigators only. Patient records wil reviewed for items specific to the field EKG process via a secure web portal with password protection. All information be de-identified for the purposes of statistical analysis and quality reporting

   a. Describe the plan for protecting the identifiers from improper use and disclosure.

      Patient information will be de-identified to date of service and account# at the time of the chart review for internal audits by the secondary investigator. PHI will be completely de-indentified for external reporting.

   b. Describe the plan to destroy the identifiers at the earliest opportunity that is appropriate for the research study. Identifiers may only be maintained following completion of a study if there is a legitimate reason for maintaining the data (e.g required by law, etc.).

      Identifiers will be eleminated post the initial report to internal reveiws for quality process improvement. Records maintained for the three year requirement will be identified by date of service and diagnosis only.

☐ **NO.** You are not subject to HIPAA. For additional information, please see the **Covered Entity Checklist** available on th IU Human Subjects Office website. Proceed to Section III.

☒ **YES.** Continue below:

B. Will protected health information (PHI) be utilized, accessed, collected, or generated as part of the study? For additional guidance on PHI, please refer to the definitions in the Standard Operating Procedures document.

☐ **NO.** Your research is not subject to HIPAA. However, will health information (that is not PHI) be used that is:
- ☐ De-identified?
- ☐ Part of a Limited Data Set?
  - ☐ Health information will be received from a separate covered entity from that of the investigator. You must estab a data use agreement with the entity providing the health information.
  - ☐ Health information will be obtained from within the investigator's own covered entity. No data use agreement is required.
- ☐ No health information will be utilized in any form.

☒ **YES.** Your research is subject to HIPAA. Complete the HIPAA& Recruitment Checklist.

SECTION III: PERFORMANCE SITE

☒ Indiana University
- ☐ IUB Campus. Please state school/department/location(s): _____
- ☐ IUPUI Campus. Please state school/department/location(s): _____
- ☐ Bradford Woods
- ☐ Center for Survey Research
- ☐ Center for Evaluation & Education Policy (CEEP)
- ☐ Indiana CTSI Clinical Research Center*
- ☐ Indiana Institute on Disability and Communication
- ☐ IU Simon Cancer Center*
- ☐ Krannert Institute of Cardiology*
- ☐ Kinsey Institute
- ☐ Oral Health Research Institute
- ☒ Other: IU - Terre Haute Campus

☐ Health & Hospital Corporation of Marion County
- ☐ Bell Flower Clinic
- ☐ Midtown Mental Health*
- ☐ Wishard Memorial Hospital*
  - ☐ Community Health Clinics/Centers
  - ☐ Hospital/ER
  - ☐ Non-primary care
    - ☐ Wishard Specialty Clinics
    - ☐ OB/GYN Clinics

☐ Indiana University Health (Clarian) Facilities
- ☐ Bloomington Hospital
- ☐ Beltway Centers
- ☐ Methodist Hospital
- ☐ Methodist-Affiliated Centers/Private Practices
- ☐ North Hospital
- ☐ Riley Hospital for Children
- ☐ University Hospital
- ☐ West Hospital
- ☐ Other: _____

☐ IU Health Clinics. Please list location:_____.

☐ IU Medical Group Specialty Clinic (IUMG-SC). Please list location:_____.

☐ Larue Carter Hospital

☐ Monroe County Community School Corporation. Please list school:_____.

☐ Regenstrief Institute

☐ Rehabilitation Hospital of Indiana

☐ Richard L. Roudebush Veterans Affairs Medical Center*. (Complete the Request Form for VA Research)

☐ Other: _____

** Additional information and/or approvals may be required prior to submitting and/or initiating the research. Please see the IU Human Subjects Office website and check with the specific performance site for additional information.*

B. Please list other facilities not under the direct supervision of the investigator where research-related procedures will be perform (e.g. pathology, nursing, pharmacy, radiology, counseling). *

Union Hospital Clinton, Parke County Ambulance, Vermillion County Ambulance, Commwell Medical

You must ensure these persons/facilities are kept adequately informed about the study and their research-related dutie and functions as they relate to the protection of human participants.

SECTION IV: SUBJECT POPULATION

A. **Subject Population.** Check all subject population categories below for which there is a reasonable expectation of enrollment this research study:

- ☐ **Children** (Complete the Request Form for the Inclusion of Children in Research)
- ☐ **Cognitively Impaired** (Complete the Request Form for the Inclusion of Cognitively Impaired Individuals in Research)
- ☐ **Economically/Educationally Disadvantaged**
- ☐ **Pregnant Women, Human Fetuses, or Fetal Material** (Complete the Request Form for the Inclusion of Pregnant Wome Human Fetuses, and Neonates in Research)
- ☐ **Prisoners** (Complete the Request Form for the Inclusion of Prisoners in Research)
- ☐ **Subjects Outside of U.S. Targeted for Enrollment** (Complete the Transnational Research Information Form)
- ☐ **Veterans** or research funded by the VA, utilizing VA effort, property or resources, or enrolling VA patients. (Complete tl Request Form for VA Research)
- ☐ **Students.** When there is a teacher-student relationship dynamic or when using a student subject pool, complete the follov questions:

  1. Clarify the necessity for involving students in the research:

  2. Explain how the possibility of coercion or undue influence will be minimized when informed consent is being sought

  3. Explain what genuinely equivalent alternatives are available for students who wish not to participate:

B. **Inclusion/Exclusion.**

Inclusion Criteria:

- The subject group will be limited to patients that activate Parke and Vermillion County ambulances through the e-911 dispatch centers with a chief complaint of "chest pain" including the following signs and symptoms of coronary syndrome chest pain, jaw pain, left arm pain, neck pain, nausea, shortness of breath, dizziness and sweating,

Exclusion Criteria

- Subjects will be excluded based on their inability to participate due their lack of physical and or mental capacity to assist EMS personnel with EKG acquisition.
- Subjects will be excluded based on the presentation of "life threatening" conditions that negate the priority of EKG acquisition and transmission
- Individuals under 18 years of age will be excluded from this study

C. **Number of Subjects.** State the number of subjects to be involved in the research (i.e. number of subjects who will receive research intervention, or about/from whom information or specimens will be collected) both locally and nationally (if a multi-center study).

Maximum enrollment of 1000 patients for the entire study year

NOTE: The number provided will be the maximum number of subjects approved to participate in this research.

SECTION V: RECRUITMENT

NOTE: Study information will be released to the Clinical and Translational Science Institute (CTSI) for the research study listing. To opt out of this listing requirement you will need to get opt-out approval from Dr. Anantha Shekhar, PhD, MD, Director of Indiana CTSI, prior to IRB submission. For additional information or to request opt-out approval, please cont: Patrick McGuire at (317) 278-2176 or pacmcgui@iupui.edu.

A. Is this research subject to HIPAA? (refer to Section II above)

☒ **YES.** Do not answer questions 1-3 below. Instead, complete the **HIPAA & Recruitment Checklist**.

☐ **NO.** Answer questions 1-3 below.

1. Describe how potential subjects will be initially identified (include specific source, e.g. databases, medical records, advertisements, newsletters, self-referral, physician referral, from clinics, etc.):

2. Describe how potential subjects who are identified will be contacted (e.g. letter, phone call, face-to-face) and who wil contacting them (e.g. their physician, research coordinator, nurse, etc.). Include a copy of all information to be sharec with or intended to be seen by potential subjects.

3. Is the investigator currently conducting competing studies? Competing studies refers to two or more studies wl utilize overlapping or very similar eligibility criteria.
   ☐ No.
   ☐ Yes. Please describe the plan to ensure fair and unbiased recruitment:

NOTE: Allowing the Principal Investigator or the subject to choose one study over another is rarely acceptable. Cons randomization procedures or exclusive enrollment in one study at a time.

SECTION VI: STUDY PROCEDURES

List all methods by which information or data about or from subjects will be obtained, including any drugs or devices to be used on human subjects and all procedures/interventions that are being performed that would not otherwise be performed outside of the research study [e.g. an investigational drug, a blood draw that is taken purely for research (not treatment purposes) or a standardized survey that is being completed solely for the purposes of this research]. Describe the frequency and duration of the procedures.

The subject group will be limited to patients that activate Parke and Vermillion County ambulances through the e-911 dispatch centers with a chief complaint of "chest pain" including the following signs and symptoms of coronary syndrome; chest p jaw pain, left arm pain, neck pain, nausea, shortness of breath, dizziness and sweating. Chest pain will be defined through the "Acu Chest Pain/ Acute Coronary Syndrome Protocol" as implemented by the Medical Director of EMS. Once the determination for treatment under the Chest Pain/ Acute Coronary Syndrome Protocol is made, the EMS provider will determine eligibility and assis the patient to obtain a 12 lead EKG through the utilization of the non-invasive Physioglove device. The total procedure time for obtaining the EKG has been calculated to be approximately 2-5 minutes with full patient cooperation. After acquisition the EKG w be transmitted en route to the CAH. No changes or deviations from the existing Chest Pain/ Acute Coronary Syndrome Protocol wi made throughout the course of treatment until the patient is evaluated by the CAH physician in the emergency department. Per medical direction all EMS providers are instructed that they are "not to interrupt life-saving interventions and /or ever delay transp in order to obtain or transmit an EKG". The primary purpose of early transmission of the EKG is to allow the emergency departme physician additional time to identify the proper course of treatment and deploy the appropriate resources.

Information regarding the transmission process will be collected by utilizing the EKG Transmission survey . Advanced an Basic Level providers will complete the survey at audit and review 2 times over the course of the study. The survey will gather information regarding potential challenges and successes of the transmission process.

NOTE: Please include all surveys, instruments, survey/focus group questions, etc. that will be used for this research.

SECTION VII: RISK/BENEFIT RATIO

A. State the potential risks – for example, physical, psychological, social, legal, loss of confidentiality or other – connected with the proposed procedures.

Current process for the care of the "chest pain" patient does not involve a diagnostics 12 lead. Patients currently receive non-diagnostic 3 lead cardiac monitoring to rule out arrhythmias. The primary anticipated risk for subjects would be "delay of treatment" based on technician error or equipment error. There is a potential for the subjects to experience increased anxiety or fear related to the new technology and the novice end user. Potential loss of confidentiality is also a risk.

B. State the potential benefits to be gained by the SUBJECT.

Benefits for the subject include early identification and deployment of resources to address the cardiac condition. E intervention would be a key benefit for those subjects identified as having a STEMI. Patients have the potential to experience anxiety based on the knowledge that the emergency department physician is viewing the EKG and can call in the cardiology t if needed.

C. State the potential benefits or information which may accrue to SCIENCE or SOCIETY, in general, as a result of this work.

Rural counties that do not currently have Paramedics service stand to benefit the most from this technology and process. Information from the Indiana EMS Commission and the Indiana Rural Health Association supports the need for creative soluti for rural populations with limited EMS resources. Patient assisted EKG transmission by EMT-B and EMT-A personnel will address one of the rural disparities for our growing population of cardiac patients.

D. Explain how the potential risks to subjects are reasonable in relation to anticipated benefits.

Risk

The risk for subjects is minimal. EMS technicians receive significant training regarding the time frames for acquisition (with minutes of arrival) and transmission (within 10 minutes of patient contact). Initial field testing of the Physioglove equipmer date has demonstrated that the EKG can be transmitted in less than one (1) minute. Due to the challenges of rural and ren areas the laptop solutions are designed to continuously search for a signal so that even if the transmission is delayed no fur efforts are required by the EMS staff. The supporting Medical Directors have clearly delineated the fact that patient care is nc be delayed based on difficulties related to the EKG acquisition and or transmission. Specific language within the protocol st that per medical direction all EMS providers are instructed that they are "not to interrupt life-saving interventions and /or delay transport in order to obtain or transmit an EKG".

Benefits

Cardiac care and interventions such as heart catheterization for patients experiencing a heart attack are extremely time sensitiv The benefits for the subjects of this study and to society as a whole are well established in literature. Transportation of "chest pain" patients to a definitive intervention and cardiac care plan can reduce pain, complications and death. The patients will experience a coordinated level of service as they are treated by EMT-B providers in their communities. Offering 12 lead transmissions to rural and remotely located patients can impact their overall experience with EMS in their communities. Patier have the potential to experience less anxiety as they are told by EMS "We are transmitting this tracing to the specialist so that they can have things ready when you get to the hospital".

SECTION VIII: PROTECTION PROCEDURES

A. Describe procedures for protecting against, or minimizing, the potential risks described in Section VII, including using proced that are already being performed on subjects for diagnostic, treatment, or standard purposes, when appropriate.

Risk 1 – Delay of treatment based on technology and or end user difficulties

Initial field testing of the Physioglove equipment to date has demonstrated that the EKG can be transmitted in less than on min Extensive field testing of equipment is performed prior to patient implementation to ensure consistent optimal equipn performance. Due to the challenges of rural and remote areas the laptop solutions are designed to continuously search for a si

so that even if the transmission is delayed no further efforts are required by the EMS staff. The supporting Medical Directors h clearly delineated the fact that patient care is not to be delayed based on difficulties related to the EKG acquisition an transmission. Specific language within the protocol states that per medical direction all EMS providers are instructed that they "not to interrupt life-saving interventions and /or ever delay transport in order to obtain or transmit an EKG". Extensive trai and support of EMS staff including real time feedback and technology support are in place.

Risk 2 - Potential for the subjects to experience increased anxiety or fear related to the new technology and the novice e user.

Multiple training sessions and "go live" support for EMS providers including competency test outs on equipment and transmission. Step by step guides are placed in each ambulance for frequent review of EMS providers. EMS providers are trair regarding scripting guidelines to reassure the patient that the equipment is providing essential real time communication with th emergency department physician and the cardiologist as needed. All providers receive skills evaluations prior to implementatic In addition EMS staff will receive feedback regarding process evaluations both positive and negative. Ongoing support and encouragement is provided from the research team and the medical directors to reduce EMS staff anxiety and increase confide in the new process

Risk 3- Potential for loss of confidentiality
Initial EKG completion will take place in the confines of the ambulance. The EKG will be labeled with the patient name and DOB and transmitted across the hosptial's secure server to the printer located in the emergency department. The printer is loca at the physician's desk. The only persons with access to the printer are hospital emergency department staff, primarily the physician. Once the physician reviews the EKG it will be placed in the secure medical records pick up box located at the nurse station. Medicial Records will retrieve the document and scan it in to the electronic medical record and shread the original document. The electronic medical record is secure behind the hospital firewall and is user password protected. Medical record: will be reviewed monthly by the investigator to abstract data. All data utilized for external reporting will be deindentified.

B. Explain provisions to protect privacy interests of subjects. This refers to how access to subjects will be controlled (e.g. time, place, etc. of research procedures).

Participant privacy will be protected within the ambulance through the EMS patient privacy protocols. Medical records will be reviewed by the primary and secondary investigators only. All pertinent data relayed to external sources will be de-identified

C. Is this a multi-center clinical trial?
- ☒ No. Continue to the next section.
- ☐ Yes. Is the PI the lead investigator?
  - ☐ No. Continue to the next section
  - ☐ Yes. Describe the plan for the management and communication of multi-site information that may be relevant to the protection of participants (e.g. unanticipated problems, adverse events, interim analysis, modifications, etc.).

SECTION IX: DATA SAFETY MONITORING PLAN

For all research that is **greater than minimal risk**, a Data Safety Monitoring Plan (DMSP) must be developed. This is a pla assure the research includes a system for appropriate oversight and monitoring of the conduct of the study to ensure the safet subjects and the validity and integrity of the data.

- ☒ N/A. The research is minimal risk.
- ☐ The DSMP is contained in the protocol. State where in the protocol the description is located: _____
  NOTE: Ensure that all points outlined below are addressed in the description in the protocol. If any points are not addres within the protocol, they should be addressed below.
- ☐ The DSMP is NOT contained in the protocol; however, this is a repository/database protocol and the primary risk is that of los confidentiality; thus, I do not need to complete this section.
- ☐ The DSMP is NOT contained in the protocol. Complete the questions below.

A. Who will be responsible for the data and safety monitoring? (Examples include: a DSMC or DSMB, medical mor investigator, independent physician) **Clarify if this individual or committee is independent from the sponsor an investigator.**

B. What will be monitored. (Examples include: data quality, subject recruitment, accrual, and retention, outcome and adverse e data, assessment of scientific reports or therapeutic development, results of related studies that impact subject safety, proce

designed to protect the privacy of subjects)

C. What are the procedures for analysis and interpretation of data, the actions to be taken upon specific events or endpo the procedures for communication from the data monitor to the IRB and site, and other reporting mechanisms?

D. What is the frequency of monitoring? (The appropriate frequency of data and safety monitoring will be dependent on the n and progress of the research; however, monitoring must be performed on a regular basis (e.g, at least annually).

E. What information will be reported to the IRB? (Minimally, the IRB requires the following information at the tim continuing review: 1) frequency and date(s) of monitoring; 2) summary of cumulative adverse events; 3) assessment of ext factors (i.e. scientific reports, therapeutic developments, results of related studies) that impacted the safety of subjects; 4) sum of subject privacy and research data confidentiality outcomes; and 5) any changes to the risk-benefit ratio.

SECTION X: PAYMENT FOR PARTICIPATION

A. Will subjects be paid for participation in the study (e.g. monetary, free services, gifts, course credit, including extra credit)?

☒ No. Proceed to next section.

☐ Yes. Complete items 1-3 below.

1. Explain the payment arrangements (e.g. amount and timing of payment and the proposed method of disbursement), includ reimbursement of expenses. **NOTE:** Payments must accrue and not be contingent upon completion of the study. Howev a small payment (bonus) for completion of the study may be approved by the IRB if it is found to not be persuasive for the subjects to remain in the study.

2. Justify the proposed payment arrangements described in section B. (e.g., how this proposed payment arrangement is not considered to be coercive).

3. Explain if there will be any partial payment if the subject withdraws prior to completion of the study (e.g. prorated). Note This payment may be paid at the end of the subject's participation or at the end of the study.

SECTION XI: INFORMED CONSENT PROCESS

☐ **Check here if this study will only enroll children and the parental/guardian permission (consent) process has already b explained on the Request Form for the Inclusion of Children in Research. You do not need to complete section A below**

☐ **A. I WILL be obtaining informed consent from all subjects.**

1. **When (in what timeframe) and where (what setting) will consent take place?** Indicate any waiting period betwee informing the subject and obtaining consent. The timeframe and any waiting should ensure the prospective subjects their legally authorized representatives are provided sufficient opportunity to consider whether or not to participate in study.

2. **Who will be responsible for obtaining initial and ongoing consent? (check all that apply)**

☐ Principal Investigator
☐ Co-Investigator
☐ Other (specify):

NOTE: Individuals who will be obtaining consent must be listed on the Investigator List.

a. **Explain how these individuals will be adequately trained to conduct the consent interview and answer subject's questions (check all that apply):**

- ☐ Passed the required Collaborative Institutional Training Initiative (CITI) modules
- ☐ Attended the Research Coordinator Education Program (RCEP)
- ☐ Attended the Research Coordinator Certification Program (RCCP)
- ☐ Received study-specific training from study personnel
- ☐ Other (specify): ____

b. **Indicate in what language(s) the consent interview will be conducted.**

- ☐ English
- ☐ Spanish
- ☐ Other (specify):

c. **If the consent interview will be conducted in a language other than English, state how the interview will be conducted (e.g. use of an interpreter):**

NOTE: Ensure that language-appropriate consent documents are submitted with this application.

3. **Explain how subjects' privacy will be protected during the consent process.** This refers to how access to subjec will be controlled (e.g. time, place, etc. of consent procedures).

4. **Indicate any factors that might result in the possibility of coercion or undue influence. (check all that apply)**

- ☐ the research will involve students of the investigator(s)
- ☐ the subjects will be recruited through institutions with which the PI has a close relationship
- ☐ Other (please specify):

Describe steps taken to mitigate the possible coercion:

☒ **B. I am requesting a waiver of the informed consent process (i.e. no consent document) for (check all that apply):**

- ☒ **the entire study.**
- ☐ **recruitment only (VA requirement: please see the sample language provided in VA Waivers for Recruitn located on the IU Human Subjects Office website).**
- ☐ **a specific minimal risk research activity or procedure that is part of the study: ____.**

For the IRB to grant a waiver of informed consent, the below criteria must be satisfied. Please provide a respons each criterion.

1. The research involves no more than minimal risk to the subject. If you are requesting a waiver of informed consent part of the study (e.g. recruitment or a specific minimal risk activity or procedure), please state to wl activity/procedure the waiver request applies and explain how this criterion is satisfied.

   The patient assisted EKG device is non-invasive. The primary risk are delay in treatment and anxiety related to new equipment. Safety precautions are on place to minimize the risk. Advanced and Basic Level EMT's will be asked to complete surveys regarding the transmission content. Surveys will be submitted without the individuals name in orde protect identity. There is no identified risk to the EMT staff.

2. Explain how the waiver will not adversely affect the rights and welfare of the subjects.

   Patients will receive verbal information from the technician at the time of the EKG. Patient may decline the EKG if desired. EMT staff will receive information regarding the option to complete the survey. Individuals uncomfortable submitting a survey may choose not to participate.

3. Explain how the research could not be practicably carried out without the waiver.

The completion of the EKG for early transmission is a time sensative treatment the alloted time to EKG is 5 minutes. Patients experiencing chest pain are not in a position physically, emotionally or psychologically to fully provide informed consent.

4. Explain how, if appropriate, subjects will be informed of pertinent results at the conclusion of the study.

Patients will recieve information regarding the EKG results upon arrival to the emergency department. The EKG inperpretation will be provided by the emergency department physician. EMT staff will receive survey outcomes at Audit and Review meetings.

5. The research is **NOT** FDA-regulated (i.e. The activity is NOT an experiment or does NOT involve one or more of following test articles: foods or dietary supplements that bear a nutrient content claim or a health claim, infant formu food and color additives, drugs for human use, medical devices for human use, biological products for human electronic products. Additionally, **NONE** of the following can be true:, the research involves using the test article v one or more participants, the research is being done as part of an IND or IDE submission, the data may be submitte the FDA, or the data may be held for inspection by the FDA).

6. **ONLY COMPLETE FOR RESEARCH AND DEMONSTRATION PROJECTS CONDUCTED BY SUBJECT TO THE APPROVAL OF STATE OR LOCAL GOVERNMENT OFFICIALS.** In order for the to approve a waiver of informed consent for a research or demonstration project, conducted by or subject to the appr of state or local government officials, it must NOT be FDA-regulated and be designed such that it studies, evaluates otherwise examines one of the following (check all that apply):
   - ☐ public benefit or service programs;
   - ☐ procedures for obtaining benefits or services under those programs;
   - ☐ possible changes in or alternatives to those programs or procedures; or
   - ☐ possible changes in methods or levels of payment for benefits or services under those programs.

☐ **C. I am requesting a waiver of *written documentation* of informed consent (i.e. a consent process will occur, but signature will be obtained from the subject).**

☐ Written statement regarding the research has been attached. Statement will be provided to subjects upon their reqt Please explain:

Patients will be given a brief verbal overview of the project prior to administration of the EKG. Due to nature of the prot and the patients level of pain/ distress related to chest pain written statements will be made available when the patient is to review.

For the IRB to grant a waiver of written documentation of informed consent, EITHER of the following criteria mu be met. Please indicate which criterion is met and provide an appropriate response below.

☐ 1. The only record linking the subject and the research would be the consent document and the principal risk woul potential harm resulting from a breach of confidentiality, and the research is not FDA-regulated. Each subject be asked whether the subject wants documentation linking the subject with the research and the subject's wishes govern. Please explain:

OR

☐ 2. The research presents no more than minimal risk of harm to subjects and involves no procedures for which wri consent is normally required outside of the research context. Please explain:

☐ **D. I am requesting modification to the required elements for informed consent document for:**
the entire study
☐ **a specific minimal risk research activity or procedure that is part of the study**

Check all of the required elements below that you are requesting to modify or omit from the informed consent document:

- ☐ Statement that the study involves research
- ☐ Explanation of the purposes of the research
- ☐ Expected duration of subject participation
- ☐ Description of procedures to be followed
- ☐ Identification of any procedures that are experimental
- ☐ Description of any reasonably foreseeable risks or discomforts to subjects
- ☐ Description of benefits (to subjects or others) that may reasonably be expected from the research
- ☐ Disclosure of appropriate alternative procedu or courses of treatment
- ☐ Statement describing the extent to which confidentiality of records identifying subjects will be maintained
- ☐ Explanation regarding any compensation
- ☐ Explanation of available medical treatments i injury occurs
- ☐ Contact information for questions about the research, research-related injury, or subject ri
- ☐ Statement that participation is voluntary

For the IRB to grant a modification to the required elements of informed consent, the below criteria must be satisf Please provide a response to each criterion.

1. The research involves no more than minimal risk to the subject. If you are requesting a waiver of informed consent part of the study (e.g. a specific minimal risk activity or procedure), please state to which activity/procedure the wa request applies and explain how this criterion is satisfied

2. Explain how the modification will not adversely affect the rights and welfare of the subjects.

3. Explain how the research could not be practically carried out without modification of informed consent.

4. Explain how, if appropriate, subjects will be informed of pertinent results at the conclusion of the study.

5. The research is **NOT** FDA-regulated (i.e. The activity is NOT an experiment or does NOT involve one or more of following test articles: foods or dietary supplements that bear a nutrient content claim or a health claim, infant formu food and color additives, drugs for human use, medical devices for human use, biological products for human electronic products. Additionally, **NONE** of the following can be true: the research involves using the test article one or more participants, the research is being done as part of an IND or IDE submission, the data may be submitte the FDA, or the data may be held for inspection by the FDA).

SECTION XII: ADDITIONAL REVIEWS

☒ N/A. This research does not require any additional institutional reviews. Proceed to next section.

A. Will this study specifically enroll cancer patients (e.g. is the study focused on cancer treatment or care or does the study includ control group of cancer patients) or involve cancer-related gene therapy?
- ☐ No.
- ☐ Yes. You must first obtain approval from the Scientific Review Committee (SRC) prior to submitting to the IRB. Please include that approval with your IRB study submission. Please contact the SRC at (317) 274-0930 or crosrc@iupui.edu fo additional information.
  - ☐ Check here if this study is a retrospective chart review involving cancer patients; SRC approval is NOT necessary.

B. Does the study involve recombinant DNA (e.g. gene therapy)?
- ☐ No.
- ☐ Yes. IBC or BHC protocol number:

C. Does the study involve radiation / radioactivity (e.g. x-rays, nuclear medical scans) in addition to what is used for standard clinical treatment?

☐ No

☐ Yes. Radiation Safety approval must be obtained if radiation beyond standard of care is involved. Concurrent IRB and radiation safety review is permissible; however, final IRB approval will not granted until documentation of radiation safet approval is provided.

D. Does this study involve the use of *non-cancer-related* gene therapy?

☐ No.

☐ Yes. Has the proposal been submitted to the Indiana CTSI Clinical Research Center (CRC) Advisory Committee? (NOT It is a requirement of the School of Medicine for all non-cancer related gene therapy studies to be reviewed by the CRC Advisory Committee. Additionally, it is the CRC's requirement that approval be granted from them prior to IRB submission.)

☐ No. You must submit to the CRC Advisory Committee *before* you can submit to the IRB. Please call (317) 278-3446 for more information.

☐ Yes. Include a copy of that approval with this study submission.

SECTION XIII: FEDERAL FUNDING

A. Is this research funded by a federal agency (e.g. DHHS, NIH, VA, CDC, ICTSI, etc.), or has it been submitted to a federal age for funding?

☐ No. Proceed to the next section.

☒ Yes. Please ensure copies of the entire funding proposal and DHHS-approved sample informed consent (if applicable) are available to the IRB.

NOTE: If this is a federally-funded study, you will be required to track the race and ethnicity of subjects enrolled. This is reported to the IRB at the time of continuing review.

SECTION XIV: INVESTIGATIONAL TEST ARTICLES

☒ N/A. No investigational drugs or devices are being studied in this research.

☐ This study involves a device that is exempt from the IDE requirements. Please submit the IDE Checklist or notification from t FDA confirming status of this device.

If you are studying an investigational drug or device, an IND or IDE may be required. Please see the IND Checklist or IDE Check for more information.

INVESTIGATIONAL DRUGS

A. Name of Drug Sponsor: _____

Name of Drug: _____

Study Phase: ☐ I ☐ I/II ☐ II ☐ II/III ☐ III ☐ III/IV ☐ IV

☐ An IND is not required. Please submit the IND Checklist or notification from the FDA confirming exempt status.

☐ An IND is required and has been obtained for this drug. IND Number: _____

1. Provide verification of the IND number (choose all that apply):
   ☐ Documentation from the FDA provided
   ☐ IND number included in the sponsor protocol, list the page number where the IND number is located

2. Does the investigator hold the IND?
   ☐ No
   ☐ Yes. Before approval can be granted, the investigator must meet with the Office of Research Administration staff to discuss the additional responsibilities as a sponsor of an IND. Please contact the IU Human Subjects Office at (3 274-8289 and submit documentation from them verifying this discussion has taken place.

3. Will services of the Investigational Drug Services (IDS) be used?
   ☐ Yes

☐ No. The investigator must demonstrate understanding of the handling and control of investigational test articles by reviewing the SOP for Investigational Test Articles. Check here ☐ to confirm the investigator has read the SOP and agrees to comply with the policies and procedures outlined.

INVESTIGATIONAL DEVICES

B. Name of Device Manufacturer:_____ Name of Device:_____

The IRB is required to determine whether or not the device is significant risk. To help in this determination, please provide the sponsor's documentation on the risk assessment and the rationale used in making the risk determination. ***Please provide the investigator's assessment of the device risk below:***

☐ Nonsignificant Risk (NSR) Device. Please provide a risk assessment and rationale for this risk determination:

☐ Significant Risk (SR) Device

☐ An IDE has been obtained for this device. IDE Number:_____

1. Provide verification of the IDE number (choose all that apply):
   - ☐ Documentation from the FDA provided
   - ☐ IDE number included in the sponsor protocol, list the page number where the IDE number is located

2. Does the IU affiliated investigator hold the IDE?
   - ☐ No
   - ☐ Yes. Before approval can be granted, the investigator must meet with the Office of Research Administration staff to discuss the additional responsibilities as a sponsor of an IDE. Please contact the IU Human Subjects Office at (317) 274-8289 and submit documentation from them verifying this discussion has taken place.

3. The investigator must demonstrate understanding of the handling and control of investigational test articles by reviewing the SOP for Investigational Test Articles. Check here ☐ to confirm the investigator has read the SOP and agrees to comply with the policies and procedures outlined.

EKG Transmission Process Survey

Please answer the following questions with one rated numeric response. Provide comments are needed in the box provided. Thank you for taking the time to complete this survey.

Questions	1 Strongly Disagree	2 Disagree	3 Neither	4 Agree	5 Strongly Agree	Comments
The Toughbook laptop equipment is user friendly						
EKG transmission is useful in the care of chest pain patients						
The Phyioglove is simple to apply						
Patients are easily able to assist staff with the application of the glove						
EKG transmission is possible without disrupting patient care						
I am confident that I can apply and transmit EKG's within the current protocol						

Document Date: February 10, 2012

RICHARD G. LUGAR CENTER FOR RURAL HEALTH
A DIVISION OF UNION HOSPITAL

Richard G. Lugar Center for Rural Health
1433 N 6th 1/2 St.
Terre Haute, IN 47807

Background

Emergency Cardiac Care in Parke and Vermillion Counties

Parke and Vermillion Counties are ranked in the highest category of heart disease deaths among individuals 35 years of age and over age group with 500-568 per 100,000 (Appendix A) (Centers for Disease Control and Prevention (CDC), 2008). Vermillion County has one primary ambulance service to serve its population of 16,212 (Census Bureau, 2010). Parke County has one primary ambulance service for its population of 17,339 (Census Bureau, 2010).

Vermillion County has the added challenge of being a long narrow county which makes transport times extensive from the northern end of the county (Appendix B). The Vermillion County Ambulance service is not a paramedic level provider. Parke County (Appendix C) does provide paramedic level services. However, there are occasions when all paramedics are on another scene and an advanced level provider will be required to respond.

In recognition of the challenges for cardiac patients in this area, solutions are being investigated to facilitate decreased delays in the treatment of these patients. One such delay occurs with the care of the acute ST elevation Myocardial Infarction (STEMI) patient. For these patients the STEMI is not identified until the patient arrives at the local Critical Access Hospital (CAH). By the time the patient arrives at the CAH many have been experiencing chest pain an extended transport time. The Centers for Medicare Services set the established best practice standard for a patient to arrive in the Cardiac Catheterization Suite within 90 minutes. Symptom-to-balloon time is a key predictor of whether or not a patient will experience a major adverse cardiac event (MACE) within six months (Soon, Chan and Tan 2007). Current best practice often will achieve a door to balloon times of less than 60 minutes. Pre-hospital activation of the Cardiac Catheterization Team supported by Electrocardiograph (EKG) transmission can

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consistently produce door-to-balloon times less than 60 minutes (Bachour, et al. 2007). Dr. Michael Lemay of Ottawa Heart Institute published support for paramedic field transmission by demonstrating that "patients with blocked arteries that were fast-tracked to angioplasty" demonstrated a 50% reduction in mortality (French and Koenig, 2009). Patients with door-to-balloon times of longer than two hours demonstrate a 41% to 62% increased risk of mortality (Cannon, et al. 2000).

As early as 2006 the Journal for Emergency Medicine published the following "10 Reasons to Perform a Pre-hospital EKG";

1. *Does not significantly delay transport.*
2. *Takes only one or two minutes to perform.*
3. *Quality is increasingly high.*
4. *Allows early diagnosis of AMI.*
5. *Can be used to identify patients for pre-hospital lytic therapy.*
6. *Allows a pre-alert to the hospital for a STEMI patient.*
7. *Gives the cath lab personnel time to prepare.*
8. *Provides the ED with an ECG to compare to past ECGs and to the one performed on ED arrival.*
9. *Improves patient outcomes.*
10. *Makes EMS an integral part of the chest pain team. (Slovis, 2006)*

Multiple studies have shown that field transmission of EKGs can reduce door to balloon time significantly (Feldman, et al. 2005) (Terkelsen, et al. 2002). Emergency Medical Systems (EMS) field acquisition and transmission of EKGs has been proven to impact door-to-balloon times by an average of

15.4 minutes (Bachour, et al. 2007). Best practice demonstrates that acute coronary syndrome patients will benefit directly from decreased balloon times. Early EKG transmission can reduce door to balloon times for rural patients. The challenge of the rural ambulance services to advance provider levels of training continues to be an ongoing financial challenge. Union Hospital's Richard G Lugar Center supports the pilot of this protocol to evaluate its potential to impact early intervention for this high risk cardiac population.

Rationale and Specific Aims

The primary purpose of this study is to evaluate the effectiveness of patient assisted 12 Lead EKG acquisition and transmission for basic and advanced level providers in rural areas. This is a focused trial of patient-assisted EKG transmission from the field to the nearest receiving facility for basic and advanced level providers. The pilot study time line is one year from the receipt of IRB approval. This protocol applies to Parke and Vermillion County Ambulance services only. Union Hospital's Richard G. Lugar Center for Rural Health, Telemedicine and Innovative Technologies Department, is investigating options for field transmission specifically in relation to door to balloon times and STEMI care. This is a time sensitive grant funded project sponsored by the United States Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Office for Advancement of Telehealth (OAT). The project scope is limited to field transmission of EKGs for the care of the acute coronary patient experiencing a STEMI. This project is budget neutral and there are no related BLS charges or income revenue streams. All equipment purchases will be supported through grant funds. It is our belief that with assistance of new technology, basic and advanced level providers can transmit the EKG to the Critical Access Hospital (CAH) prior to a patient's arrival at the facility. This early

notification would allow for coordination of the cardiac catheterization team and a paramedic service to transport the patient from the CAH to the nearest facility with Percutaneous Coronary Intervention (PCI) capabilities. In 2010 the receiving CAH treated a total of 160 chest pain patients in the Emergency Department. Of those patients, 23 (14%) were diagnosed with acute Myocardial Infarction. 18 of those 23 patients arrived by ambulance. Implementation of a 12 Lead EKG program has the ability to impact 160 rural cardiac patients per year. The goal of this project is to decrease door to reperfusion time to less than 90 minutes to improve cardiac outcomes and decrease mortality for rural patients.

Inclusion/Exclusion Criteria

Inclusion Criteria:

- The subject group will be limited to patients that activate Parke and Vermillion County ambulances through the e-911 dispatch centers with a chief complaint of "chest pain" including the following signs and symptoms of coronary syndrome; chest pain, jaw pain, left arm pain, neck pain, nausea, shortness of breath, dizziness and sweating,

Exclusion Criteria

- Subjects will be excluded based on their inability to participate due their lack of physical and or mental capacity to assist EMS personnel with EKG acquisition.
- Subjects will be excluded based on the presentation of "life threatening" conditions that negate the priority of EKG transmission

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Enrollment/Randomization

The subject group will be limited to patients that activate Parke and Vermillion County ambulances through the e-911 dispatch centers with a chief complaint of "chest pain" including the following signs and symptoms of coronary syndrome; chest pain, jaw pain, left arm pain, neck pain, nausea, shortness of breath, dizziness and sweating. The subject group will be limited to those patients who activate the Parke County and or Vermillion County ambulance services with a chief complaint of "chest pain". Chest pain will be defined through the "Acute Chest Pain/ Acute Coronary Syndrome Protocol" (Appendix D) as implemented by the Medical Director of EMS. Subjects meeting exclusion criteria will not participate.

Study Procedures

The subject group will be limited to patients that activate Parke and Vermillion County ambulances through the e-911 dispatch centers with a chief complaint of "chest pain" including the following signs and symptoms of coronary syndrome; chest pain, jaw pain, left arm pain, neck pain, nausea, shortness of breath, dizziness and sweating. Chest pain will be defined through the "Acute Chest Pain/ Acute Coronary Syndrome Protocol" as implemented by the Medical Director of EMS. Once the determination for treatment under the Chest Pain/ Acute Coronary Syndrome Protocol is made, the EMS provider will determine eligibility and assist the patient to obtain a 12 lead EKG through the utilization of the non-invasive Physioglove device. Patients will be given a brief overview of the device as scripted prior to the procedure. Patients will be provided with Study Information Sheets upon request. The total procedure time for obtaining the EKG has been calculated to be approximately 2-5 minutes with full patient cooperation. After acquisition the EKG will be transmitted en route to the CAH. No changes or

deviations from the existing Chest Pain/ Acute Coronary Syndrome Protocol will made throughout the course of treatment until the patient is evaluated by the CAH physician in the emergency department. Per medical direction all EMS providers are instructed that they are "not to interrupt life-saving interventions and /or ever delay transport in order to obtain or transmit an EKG". The primary purpose of early transmission of the EKG is to allow the emergency department physician additional time to identify the proper course of treatment and deploy the appropriate resources.

Data Collection

Quantitative data will be collected through a retrospective review of closed patient records including emergency medical services run sheets, CAH emergency department records and records from the receiving PCI facility. Data points will be collected regarding the timing of the following; EMS dispatch, scene arrival, EKG obtained, EKG transmitted, CAH arrival time, cardiac catheterization team activation as identified by "Code STEMI" initiation, PCI facility arrival time and overall door to balloon times. Measurement of the components in the actual EKG transmission process will include a review of the amount of time that it takes to transmit the EKG via review of server logs and printer records. Clarity of the transmitted document will be graded on a 1-10 scale verified through via a review of 10% of all AMI patients transported. Transmission reviews will be randomized to ensure sample size. Qualitative data will include feedback on process from EMS providers, emergency department staff, and process improvement team members including AMI Team and Audit and Review. The data will be collected through utilization of EKG Transmission Process standardized survey form (Appendix G).

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Results will be reported to the Emergency Medical System (EMS) commission at the completion of the project. Updates are provided through Union Hospitals' Acute Myocardial Infarction- Quality Improvement Team on a monthly basis and to Audit and Review quarterly. In addition, there will be full disclosure of challenges related to the project and specific feedback related to adherence to protocols and patient outcomes to all entities including the EMS Commission, HRSA, OAT and the IRB.

Reporting of Adverse Events or Unanticipated Problems involving Risk to Participants or Others

The PI will make full report of "adverse and or unanticipated problems" through the appropriate internal chain of command related to the incident. Appropriate and timely communication to HRSA, OAT and the IRB will be made in accordance with current policy.

Study Withdrawal/Discontinuation

Subjects can withdraw from the study at any point within the process of obtaining the EKG by indicating that they would not like to participate in the procedure. This process aligns with the EMS procedure for refusal of treatment that is currently in place,

Statistical Considerations

This is a proposed study utilizing post hoc analyses of existing documentation and only descriptive statistical data will be collected for this study; this study does not propose any experimental designs, manipulation of independent variable(s), or any pre- or post-test assessment of outcomes; therefore no inferential statistical analyses are proposed.

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Privacy/Confidentiality Issues

Participant privacy will be protected within the ambulance through the EMS patient privacy protocols. Medical records will be reviewed by the primary and secondary investigators only. All pertinent data relayed to AMI team, Audit and Review and the EMS Commission will be de-identified. HIPAA compliance will be maintained in accordance with facility policy.

Follow-up and Record Retention

The duration of the study is one year. All de-identified patient information will be collected and securely stored by the principle investigator for a three year period. Closed patient records will be accessed by the principle and secondary investigators only. Patients will be identified for chart review through by an EKG transmission server report that is generated for chest pain patients. Chart reviews will be conducted on closed patient records by utilizing IBEX and HPF electronic medical record systems via a secure web portal. All information utilized for the reporting of trends and outcomes will be de-identified.

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(AppendixA)

Indiana — Heart Disease Death Rates
Total Population, Ages 35+, 2000 – 2006

Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

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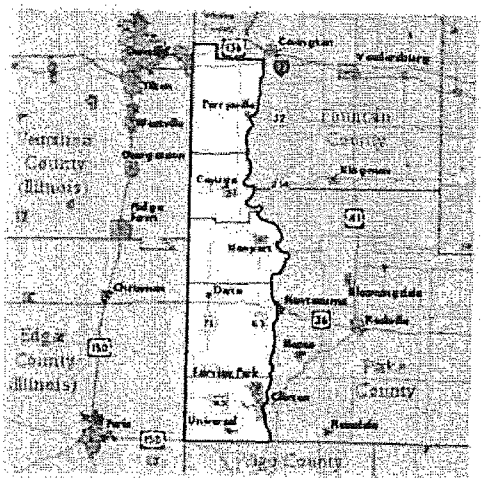
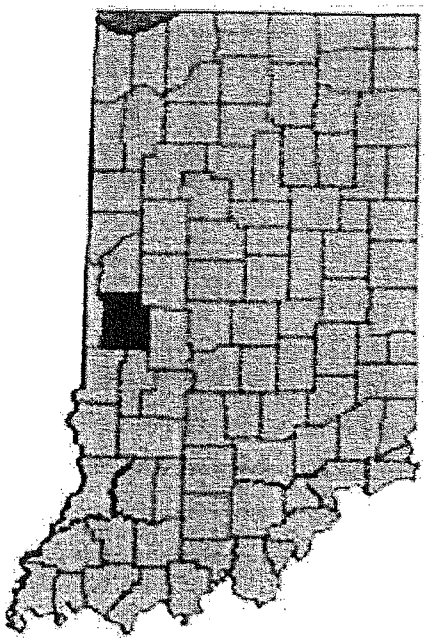
(Appendix B)



Vermillion County Map

(Vermillion County Highlighted White)

(Appendix C)



Parke County Area

(Parke County Highlighted Black

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(Appendix D)

Chest Pain/Suspected Acute Coronary Syndrome Protocol

Adult Treatment Protocol 200.19: Chest Pain/Suspected Acute Coronary Syndrome
NOTE: This protocol applies to any patient complaining of chest discomfort or with any angina equivalent suggesting possibility of Acute Coronary Syndrome including; chest pain, arm or neck pain, jaw pain, shortness of breath, nausea, sweating.

Basic:

1. Perform General Initial Medical Care (Protocol #200.00), considering ALS care.
2. ***Administer four (4) 81 mg chewable aspirin*** for patient to chew and swallow if able to maintain airway and gag reflex is intact.
3. Acquire EKG via application of Physioglove within five minutes
4. Transmit to nearest receiving facility
5. Assist patient, family, or caregiver with the administration of the patient's own ***sublingual or spray nitroglycerin as in 9a below.***

Advanced:

1. Perform General Initial Medical Care (Protocol #200.00).
2. ***Administer four (4) 81 mg chewable aspirin*** for patient to chew and swallow if able to maintain airway and gag reflex is intact.
4. Acquire EKG via application of Physioglove within 5 minutes
5. Transmit to nearest receiving facility
6. Initiate IV with ***0.9% NS TKO***
7. Draw labs
8. Obtain blood glucose level
9. Place patient on a monitor
10. Assist patient, family, or caregiver with the administration of the patient's own ***sublingual or spray nitroglycerin.***

Do not interrupt life-saving interventions and/or delay transport to obtain or transmit EKG.

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(Appendix E)

Procedure for Physioglove EKG Acquisition

The following procedure is proposed for EKG acquisition and transmission by advanced and basic level providers.

1) Login to the program
2) Click on "New Patient" button and enter patient name and date of birth
3) Inspect leads and apply conductive gel

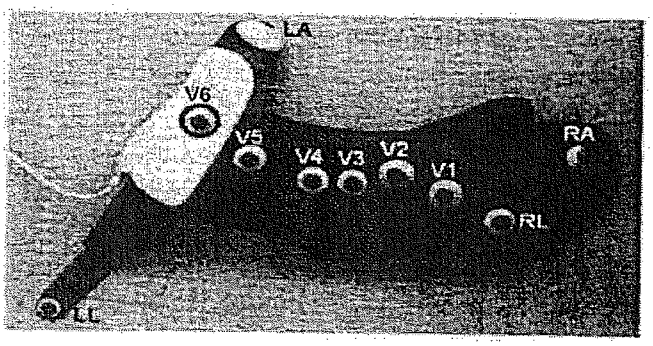

Figure 1 - PhysioGlove component

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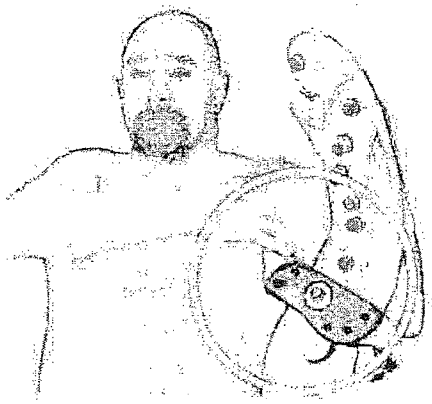
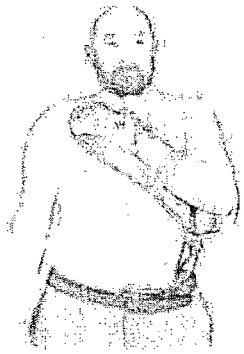
4) Assist patient to apply glove to left arm with all electrodes facing the body



5) Assist patient to position glove making sure that all leads have contact



6) Place the LA as high as possible under the left armpit

7) Encourage patient to lie still and breath normally during the tracing

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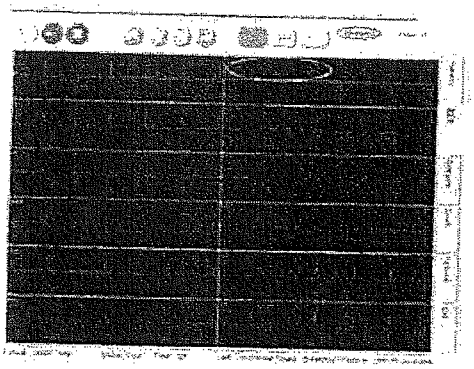

Figure 12 - Electrode and lead fault indicators: PC screen

8) Verify all leads present on the EKG monitor screen

9) Capture 12 lead using the one touch "record" button

10) Select the receiving facility from the list

11) Transmit tracing to nearest facility by selecting the print/ email option

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(Appendix F)

12 Lead EKG Acquisition and Transmission Protocol

Preamble

Rapid diagnosis of acute myocardial infarction is essential to initiating appropriate treatment and improving outcomes. In selected practice environments, pre-hospital EKG's may facilitate emergency department treatment or may facilitate primary triage to appropriate cardiac care centers.

Requirements

1) Fully trained basic and advanced level providers

2) Certification in 12 lead protocol by the medical director.

Indications

Adult Treatment Protocol 200.19: Chest Pain/Suspected Acute Coronary Syndrome

NOTE: This protocol applies to any patient complaining of chest discomfort or with any angina equivalent suggesting possibility of Acute Coronary Syndrome including; chest pain, arm or neck pain, jaw pain, shortness of breath, nausea, sweating.

Procedure

Obtain EKG as outlined in EKG Acquisition and Transmission procedure

Documentation Requirements

1. The EMS personnel inputs the patient name and date of birth on

the 12 lead ECG tracing.

2. Maintain HIPAA compliance standards for patient privacy

Education/Certification Requirements

1. Attend in-depth classes and lectures on signs and symptoms of acute coronary syndromes.

2. Attend in-depth classes in the operation of the physioglove and performance of 12 lead ECG.

3. Pass a written and practical examination.

Recertification Requirements

1. Review class and recertification is required every 12 months.

Quality Assurance Requirements

1. The Medical Director or designee will review all instances where this protocol is used. At a minimum, the following will be assessed:

- appropriateness of implementation
- adherence to protocol
- any deviation from the protocol
- corrective actions if indicated

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Questions	1 Strongly Disagree	2 Disagree	3 Neither	4 Agree	5 Strongly Agree	Comments
The Toughbook laptop equipment is user friendly						
EKG transmission is useful in the care of chest pain patients						
The Phyioglove is simple to apply						
Patients are easily able to assist staff with the application of the glove						
EKG transmission is possible without disrupting patient care						
I am confident that I can apply and transmit EKG's within the current protocol						

(Appendix G)

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Terkelsen, C, et al. "Telemedicine used for remote diagnosing in patients suspected of acute myocardial infarction." *Journal of Internal Madicine*, 2002: 412-420.

INDIANA UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB)

HIPAA & RECRUITMENT CHECKLIST

IRB STUDY NUMBER: 1202008019
PRINCIPAL INVESTIGATOR: James A. Turner, DO
DOCUMENT DATE: February 9, 2012

You must complete this checklist **if you are a Covered Entity or you are involving a covered entity in your research A protected health information (PHI) will be utilized, accessed, collected, or generated as part of the study.** Federal priv regulations impact how you may use an individual's health information to identify, recruit and contact potential research subje Under the Health Insurance Portability and Accountability Act (HIPAA) recruitment is considered research and requires eithe authorization or a waiver of authorization.

While an authorization or waiver of authorization may not always be required by HIPAA, Indiana University policy requires that subject be contacted by someone the patient would recognize as being involved in their care.

Please type only in the gray boxes. To mark a box as checked, double-click the box, select "checked", and click "OK".

Section I: Recruitment Strategies

Please describe how you will handle recruitment for your study:

1. Describe how potential subjects will be initially identified (include specific source, e.g. databases, medical recc advertisements, newsletters, self-referral, physician referral, from clinics, etc.):
   The subject group will consist of patients that activate EMS via e-911 in Parke and Vermillion Counties. Selection wil based on coronary syndrome symptoms including;chest pain, nausea, sweating, difficulty breathing, left arm or jaw p

2. Describe how potential subjects who are identified will be contacted (e.g. letter, phone call, face-to-face) and who wil contacting them (e.g. their physician, research coordinator, nurse, etc.). Include a copy of all information to be shared wit intended to be seen by potential subjects.
   Patients will not be contacted for participation in this study

3. Is the investigator currently conducting competing studies? Competing studies refers to two or more studies which uti overlapping or very similar eligibility criteria.
   ☒ No.
   ☐ Yes. Please describe the plan to ensure fair and unbiased recruitment:

   NOTE: Allowing the Principal Investigator or the subject to choose one study over another is rarely acceptable. Cons randomization procedures or exclusive enrollment in one study at a time.

Please check <u>all</u> the recruitment strategies below that will be utilized.

Please be aware that recruitment includes identification, review of records to determine eligibility or any contact to detern a potential subject's interest in a study.

☐ 1. **<u>Care Provider</u>:** Recruitment will be done by the researcher who is a physician, dentist, nurse or other licer independent practitioner who has provided care for the patient.

Neither an Authorization from the Subject nor approval to Waive Authorization from the IRB is required.

☐ 2. **<u>Authorized Delegate – Same Organization</u>:** Recruitment will be done by a researcher who did not provide care for patient, but who will act as an authorized delegate of the treatment provider and who is part of the same Departmer practice plan. (In the case of the Departments of Pediatrics, Surgery and Medicine, this will be limited to provi within the same Division.) This may include the researcher's coordinator as long as the Research Coordinator is pai the same Division, Department or Practice Plan as the PI or co-investigator.

The researcher must obtain approval from the treatment provider to act as a representative contacting the poter subject. For example: "I am a colleague of Dr. "X", or I work for Dr. X who gave me permission to contact regarding...." However, the IRB will judge the appropriateness of this approach on a case-by-case basis.

Neither an Authorization from the Subject nor approval to Waive Authorization from the IRB is required.

☒ 3. **Authorized Delegate – Separate Organization:** If the researcher is not the treatment provider and is not part of same Division, Department or practice plan of the treatment provider, then contact must be made as follows: (NO This includes Research Coordinators who are not part of the treatment provider's Division, Department or prac plan.). Please check all that apply.

☐ The treatment provider will direct the prospective subject to contact the researcher.

Neither an Authorization from the Subject nor approval to Waive Authorization from the IRB is required.

☐ The treatment provider will obtain an authorization from the potential subject to release the subject's demogra and/or health information to the researcher.

Submit an Authorization for recruitment for IRB Approval.

☒ Neither of the previous options applies to this study. A waiver of authorization will be required, but will only allowed in limited circumstances where the appropriate justification is provided to the IRB.

Complete the Waiver of Authorization Section on this Checklist.

☐ 4. **Self Referral** – A subject responds to an ad, online listing, or media relations effort for a specific study, or places a call regarding research studies in general.

☐ If you need to do a basic initial screening, you may gather minimal information necessary to determine whether individual is eligible for further screening and/or enrollment. For instance, obtaining the individual's cor information and explaining two or three major inclusion/exclusion criteria would be acceptable. Covering the er Informed Consent or an exhaustive list of inclusion/exclusion criteria does not constitute a "basic" initial screeni

Neither an Authorization from the Subject nor approval to Waive Authorization from the IRB is required.

☐ If you need to gather additional detail about an individual's health to determine the individual's eligibility authorization or waiver of authorization is required. Please note that a telephone script must be submitted unles authorization will be obtained.

Submit an Authorization for recruitment for IRB Approval or Complete the Waiver of Authorization Sectio this Checklist.

☐ If you wish to add an individual's information to an IRB-approved recruitment database for future research authorization or waiver of authorization is required. (See database questions below.)

Submit an Authorization for recruitment for IRB Approval or Complete the Waiver of Authorization Sectio this Checklist.

☐ If you wish to refer the individual to another research area/department, you must give the potential subject researcher's contact information*:

Neither an Authorization from the Subject nor approval to Waive Authorization from the IRB is required.

☐ Recruitment practices that were approved prior to April 14, 2003, which do not fall into any of the above li categories.

Complete the Waiver of Authorization Section on this Checklist.

* *This does not prohibit or interfere with the ability to refer patients for treatment purposes to other providers.*

Section II: Recruitment Databases

Instructions: This section applies to databases that are developed and/or used exclusively for research or recruitment purposes not for patient care. Select from the Recruitment Strategies ABOVE for recruitment strategies involving clinical databases (physician patient databases, CareWeb, Regenstrief, etc.).

Attachment #6

Your Blood Glucose reading today was_____

These readings should be followed up by your family physician or the Diabetes Education clinic
Fasting glucose > 126
Random Glucose > 200

Major Risk Factors for Diabetes:

- **Family History of diabetes**
- **Females with previous Gestational Diabetes**
- **Obesity**
- **Lack of regular exercise**
- **High blood pressure**
- **Elevated Cholesterol**

If you have at least 2 of these risk factors, PLUS an elevated screening **the EMT or Paramedic has recommended that you follow up for further testing with your physician or the Diabetes Education Center.** *Early detection= early intervention and better quality of*

	The following treatment was provided to you by the Fire Department
	After determining that your blood sugar was low, the EMT or Paramedic gave you additional glucose to treat your low blood sugar.
	Patient was transported to hospital for further treatment of Low Blood sugar
	If your blood sugar was low and you have chosen to stay home, you should eat or drink something and re-check your blood sugar in 15 minutes. You may need to repeat this until your blood sugar is above 70. *CALL 9-1-1 I MMEDIATELY IF YOUR CONDITION WORSENS*
	Your blood sugar was abnormally elevated(> 200) but does not require immediate ambulance transport or hospitalization. The EMT or Paramedic recommended that you get further testing from your physician or the Diabetic Education Center.
	Your blood sugar was abnormally elevated (>500), it is strongly advised that you are transported to the hospital for immediate treatment and evaluation. Diabetic emergencies include low blood sugar, but also high blood sugar. Very high blood sugar is a medical emergency and should be treated.
	You have tested >500 on your blood glucose , and along with other symptoms noted today, you are being transported to the hospital for further evaluation.

Riverview Health

Diabetes Education Center:
395 Westfield Rd.
Noblesville, IN 46060
317.776.7233
Hours: Monday-Friday: 8 am to 4:30 pm

The certified diabetes educators and staff of the Diabetes Education Center at Riverview Health provide education, prevention techniques and diverse treatments to those living with diabetes.

Through our educational program, accredited by the American Diabetes Association, we help individuals living with diabetes—whether they're newly diagnosed or in need of self-management tools—learn how to better manage their condition.

Diabetes education is offered on an inpatient and outpatient basis. Inpatients receive on-site consultations, while outpatients have the option of diabetes self-management classes or individual consultations.

The Diabetes Education Center at Riverview Health provides comprehensive instruction on: Nutrition/meal planning

- Diabetes medications
- Insulin administration
- Blood glucose monitoring
- Risk reduction

Our diabetes educators maintain clinical and dietary certifications. And our patient-focused educational program meets the American Diabetes Association's national standards for diabetes self-management education.

American Diabetes Association.

We Care about you!

Did you know:

- **There are 7 million people *undiagnosed* with diabetes**
- **Another 79 million people have pre-diabetes**
- **Mortality rates for diabetes are *7 times higher than the general population (11%)***
- **In 2004, heart disease was noted on 68% of diabetic death certificates**
- **In 2005-2008, 67% of diabetic patients also had hypertension**
- **Diabetes is the leading cause of blindness**
- **Diabetes is the leading cause of kidney disease**
- **60-70% of people with diabetes have neuropathy**

Proposal for Expanding EMT scope of practice to include Blood Glucose monitoring

Stephanie Freeman RN, BSN, CEN (pending MSN nursing Education)

June 20, 2014

Outline for Discussion

1. Introduction:

My name is Stephanie Freeman RN, BSN, CEN. I am currently in the final semester of my Master's in nursing Education (MSN) through Anderson University in Anderson Indiana. I am working on my capstone project which is policy and leadership. I earned my BSN from Ball State University in 1988. I have been working in the Emergency Department for the past 16 years, and teaching cardiology, neurology, diabetes and endocrine at Ivy Tech Community College for 2 years.

2. Objective:

To request approval of an expanded role of the Emergency Medical Technicians by including blood glucose monitoring in their scope of practice.
This is initially being requested as a non-rule policy for a trial in the Noblesville/ Hamilton county area, under the support and medical direction of Dr. Tim Root (see letter), Chief of Noblesville EMS James Macky (see letter) and EMS Education Coordinator of Riverview Health Stephen Freeman AS, EMT-P.
The proposed trial time is 6 months.

3. Have we been asking the wrong question?

Why should EMT's do glucometers? They "can't do anything about it anyway".

The type 2 diabetic epidemic is upon us and estimated to get worse. Maybe the more appropriate question is:
"Why do EMT's need be utilized along with paramedics to obtain *baseline* blood glucose readings, and to identify hyperglycemic emergencies, and screenings for "at-risk, person ill"?
EMS screening of at-risk patients the community and early detection of the 35% of the population that is undiagnosed or pre-diabetic, can contribute to the overall health of the community. Recognition of hyperglycemic emergencies can prevent death to elderly patients that do not recognize the symptoms and present with vague symptoms.

4. Scenarios:

#1: Dispatch calls you for "person ill". Your BLS crew arrives to find a 52 year old female, weak and "just doesn't feel good", but she doesn't think she is sick enough to go to the hospital. The only other complaint is a headache and the patient says she is "kind of thirsty". The EMT doesn't recognize any obvious problem, the patient denies known history of diabetes and her symptoms are vague. The patient refuses transport and decides to stay home. Two weeks later, EMS is called to the same residence, this time found unresponsive by her daughter who hasn't heard from her in 3 days. She has been lying on the floor for at least 3 days, is suspected of having a possible CVA, will have rhabdomyolosis, renal failure and a poor

prognosis or death. **(Based on true events as seen in the ER).**

#2: The BLS crew responds to the same situation as described above. The EMT obtains vital signs including a glucose check which reveals an elevated blood sugar of >500. The EMT has been educated on clinical presentation of Hyperglycemic- Hyperosmolar Non-ketotic Syndrome (HHS) typically seen in type 2 diabetes, and is suspicious that this could be more serious than what the patient believes. **HHS is associated with a mortality rate of >11% in type 2 diabetes and can be unrecognized for 10 years, having slow vague onset of symptoms.** The EMT makes a sound judgment to inform the patient or family that she may have a serious condition involving high blood sugar and encourages transport for emergency medical care. Outcome and prognosis is improved because of EMT education, assessment and the right tools.

Which scenario demonstrates better practice for the community? The public looks to us for guidance. If we have the opportunity and knowledge to deliver the best patient care possible, shouldn't we? Early detection= earlier treatment= improved outcomes.

EMS can affect that 10 year "window of opportunity"

4. **Why should EMS be concerned? This is the future for the EMS patient. Diabetes is not going away and it will get worse, with more calls, sicker patients and more emergencies.**

   The American Diabetes reports:

- There are 7 million people undiagnosed with diabetes (3%), (Burden of Diabetes in Indiana, 2011).
- 79 million people have pre-diabetes (35% of the US population), (Burden of Diabetes in Indiana, 2011). ***Total percentage = 38% either undiagnosed or at risk pre-diabetic in Indiana.***
- Mortality rates for diabetes are 7 times higher than the general population (11%)
- In 2004, heart disease was noted on 68% of diabetes death certificates
- In 2005-2008, 67% of diabetic patients also had hypertension
- Diabetes is the leading cause of blindness
- Diabetes is the leading cause of kidney disease
- 60-70% of people with diabetes have neuropathy
- More than 60% of non-traumatic amputations are related to diabetes
- Diabetes is an expensive disease to manage (Dall, 2010). A recent study estimated the costs of diabetes care is ***$245 billion in 2012***, higher than the previously estimate of $174 billion in 2007. ***This represents a 41% increase over a five year period***. The cost of caring for a diabetic patient is 2.3 times higher than a non-diabetic patient (Statistics

about Diabetes, 2014), and represents a burden of $700 annually for each American (Dall, 2010).

5. What positive impact would this change have?

The EMS system could have significant impact on community screening and facilitating education through referral and support programs. Benefits of educating EMT's to perform glucose monitoring include:

1) More glucose screenings will ***prevent or decrease the overall prevalance of diabetes in the community***, whichwill lead to decreased costs of care for diabetic patients. This may be known as the "fifth" vital sign, obtained in the SAMPLE history and assessment along with blood pressure and pulse. Blood glucose can be checked for a diabetic call, but EMS is the first healthcare contact, usually in the patient's home, that gives them the ***unique opportunity*** to screen at-risk patients.
2) The ability to establish a ***baseline*** blood glucose reading before admistering oral glucose & for accurate documentation and insurance reimbursement.
3) The ability to ***rule-out low blood glucose*** as a cause for altered level of consciousness (seizures or CVA) in emergent situations.
4) in the event of a busy ALS crew performing ALS skills, they would have the capabililty to ***assist the medic*** by performing a glucose check,
5) It would be in the best interest of EMS if they were actively involved in a ***pro-active, preventative process***. The undiagnosed and untreated diabetic patients in their district ***will get sicker***, they will call more frequently and will have more comorbidities and complications when they do call.
6) ***Better morale and pride knowing they have the power to make a difference*** if they detect diabetes early, that patient will have the opportunity to make changes that will keep them healthier longer and possibly prevent complications. Making a difference is why we do the job!

6. How can this be implemented?

<u>Proposed Policy Statement:</u>

The EMT will perform a blood glucose on a patient when hypoglycemia, suspected hyperglycemia (for detection of HHS or DKA), or as a screening for patients that are at-risk for undiagnosed Type 2 diabetes.

It is important that the first responding units to a scene have the ability to distinguish the potential possibility of a diabetic problem existing with their patient. Not only are we concerned about the possibility of a hypoglycemic episode, but a life-threatening hyperglycemic episode such as Hyperglycemic-Hyperosmolar Non-ketotic Syndrome (HHNS/ HHS) or Diabetic

Ketoacidosis (DKA). It is essential that the emergency responders be able to evaluate the medical condition of their patient in order to administer the most appropriate care.

The EMT should be educated and trained on the signs and symptoms of all three possibilities, but most importantly the difference in symptoms of hypo and hyperglycemia. The patient may be exhibiting signs and symptoms of a vague illness with general malaise, but a blood glucose check could reveal the early onset HHNS or DKA. An elevated glucose reading in a patient with undiagnosed diabetes translates to informing the patient that he needs further testing and offering that patient the opportunity to obtain early treatment and avoid life altering complications. Early identification is key to early intervention. Elevated blood glucose results can persuade, a patient to go to the emergency department for further evaluation and possibly life-saving treatment. On the reverse side, with a low blood glucose reading, the EMT could administer oral glucose bringing the patient up to a more homeostatic acceptable level.

Also with the administration of a baseline blood glucose test, the EMT may be able to distinguish between the signs and symptoms of a diabetic episode or that of a possible stroke or altered mental status. The establishment of base line readings with the patient is vital and need to be obtained early in order for treatment to be determined and further evaluated. Untreated HHNS, can result in severe dehydration, possible seizures, coma and eventually death.

Scope:

The blood glucose test may be performed by the Emergency Medical Technician , included when vital signs are obtained in the SAMPLE history and assessment. Any EMT properly trained in the procedure, operating in the Riverview EMS trial study may perform the blood glucose check.

Definitions:

Hyperglycemia is defined by the American Diabetes Association and CDC as a

- Fasting glucose of >126
- Random glucose of >200
- 2 hour post meal >200

Hypoglycemia is defined as glucose <70

Symptoms of hypoglycemia:

- Shaking or trembling
- Tachycardia
- Tingling
- Diaphoresis
- Cool,Pale skin
- Confusion / dizziness / decreased level of consciousness / hallucinations
- Hunger
- Mood changes- combative, crying
- Headache / blurred vision

Symptoms of hyperglycemia:

Hyperglycemic-Hyperosmolar Syndrome (HHS).

More common in Type 2 diabetes

Polyuria (frequent urination)
Polydipsia (thirst)
Polyphagia (hunger)
Hot, dry skin
Weakness
Signs of dehydration
Altered level of consciousness (seizures, lethargic)
May or may Not have any history diabetes (Hinkle, 2014)

Diabetic Ketoacidosis (DKA) –

more common in Type 1 diabetics (insulin dependent) may *also* have:

Fruity breath (due to acidosis)
Abdominal pain
Nausea / vomiting
Marked fatigue
Irregular breathing (Kussmaul's Respirations- very deep, not labored, breaths)
(Hinkle, 2014)

Action Steps:

1. During the SAMPLE assessment, the EMT will determine if the patient has a hisotry of diabetes or displays signs of hyper or hypoglycemia. The EMT should also be observant for diabetes identification bracelets, or medications present.

2. The EMT will obtain a blood glucose reading
3. If any of the above symptoms or multiple combinations of symptoms exist, the patient's blood glucose MUST be checked! After a glucose reading has been obtained, the EMT will consider the following guidelines.

If glucose under 60:

- consider oral glucose. Patient must be conscious and able to swallow.
- consider notification of ALS unit

If glucose over 70 but under 200:

- recommend patient seek further medical evaluation
- ALERT information given to patient with referral information

If glucose over 200:

- recommend patient be transported for further medical evaluation
- consider notification of ALS unit
- ALERT information given to patient with referral information

Notification of ALS unit is influenced by availability of unit, estimated time lapse for ALS to arrive, transport time to hospital, and general overall presentation of patient.

7. Data:

Data included on the run report is meant to be quick & simple for EMT's and Paramedics. There are 5 risk factors to check, along with age, gender and brochure information.

NOTE: THE PRIORITY FOR EMS IS THE NATURE OF THE EMERGENCY AT HAND.

Run Report Trial Data for EMT / Paramedic Glucometers

Date	High Alert Brochure and information for follow-up	Additional Information/ notes (transported, ALS called, Patient reaction)
Patient Age		
Gender		
Blood Glucose Reading		
Risk Factors ☑		
Obesity		
Hypertension		
Gestational DM		
Family HX DM		
Regular Exercise? Y / N		

The EMT will complete the glucometer reading on the brochure, check the appropriate line regarding action taken by the EMT/ paramedic, and inform the patient of referral resources (Riverview Health). No further action is needed from EMS.

8. Conclusion:

After researching the diabetic epidemic, and witnessing first-hand the many DKA or HHS emergencies that are treated in the ER, it seems that the time has come to increase efforts for early detection of type 2 diabetes. EMS can play a pro-active role in early detection. Their only role should not be to treat hypoglycemia, but provide a valuable service to the community through screening of at-risk patients and recognition of hyperglycemic patients. Glucometers and test strips are already on most of the ambulances and apparatus, it would not be a stretch to include EMT's performing glucose checks.

Additional notes:

- Amy Seeko, Lab coordinator at Riverview is agreeable to provide training to the EMS coordinator and chief Macky and potentially 2 other supervisors.
- Final cost analysis and estimates are ongoing, and I should have additional information on June 20th, during the meeting.
- Riverview Health Diabetes Education Center is extremely supportive after talking with them. They provided contact information for patient follow up.
- Feasible cost follow up: Direct access lab services offers an A1c for $15 to obtain a more accurate glucose. If this reading is >7, the patient should seek medical attention for early treatment which can prevent complications and early death from diabetes.

Thank you for considering
Sincerely,
Stephanie

Riverview
HOSPITAL

29 May, 2014

State of Indiana EMS Commission

RE: EMT Glucometer Checks

Dear Members,

As the Medical Director for the Riverview Health EMS System that operates in Hamilton County, I would be in support of the implementation of Glucometer testing for our state certified Emergency Medical Technicians. I feel that this new scope of practice would help the healthcare system by: 1) delivering the most appropriate medical care at the earliest onset of a crisis, 2) helping diagnose at-risk potential diabetics before they transform into a chronically debilitated situation.

The possibilities associated with blood glucose checks delivering early detection screenings via EMS is a step in the right direction. Diabetes will soon become a disease process that will have an overwhelming effect on the healthcare system. A pre-diabetes screening that enables any individual to obtain medical treatment earlier, avoiding prolonged complications, and taxing the healthcare system is a good thing.

The availability to treat diabetic hypoglycemic episodes at home without the added expenses of ALS interventions, again is a savings to the industry.

I would be in full support of allowing a pilot test program under my medical direction through the EMS system at Riverview Health in Hamilton County, Indiana. I understand that this process is in its infancy, but none-the-less, one that should be implemented.

If you should have any questions or concerns, or need further support, please feel free to contact me at Riverview Health Emergency Department (317) 776-7250.

Respectfully,

Timothy Root, MD

Riverview Health EMS Medical Director

NOBLESVILLE
INDIANA
Noblesville Fire Department

May 29, 2014

RE: Blood Glucose Test Site

To: The Indiana State EMS Commission

Dear members,

The Noblesville Fire Department has been approached by our sponsoring hospital, Riverview Hospital to participate in a pilot program to study the feasibility of EMT's performing blood glucose checks in the field. I do believe there may be benefit to the patients we serve in our community and throughout the State of Indiana by having this capability. The Noblesville Fire Department is glad to partnership with Riverview Hospital on such a project and will provide the use of our equipment and personnel to help facilitate the venture.

Professionally,

James Macky
Division Chief of Emergency Medical Services
City of Noblesville
Fire Department
135 S. 9th Street
Noblesville, IN 46060

O: 317.770.1419 ext 2
C: 317.646.3643
F: 317.770.2096

Attachment #7

Attachment #6

James L. Greeson, Indiana State Fire Marshal
Division of Fire and Building Safety / IDHS

EMS Branch

Field Division Report

EMS Forums: Completed EMS Forums around that State and had approximately 200 personnel in attendance.

Provider report: 2 new provider organizations since last meeting.

Vehicles processed since last Commission meeting: 9

Complaints and investigation currently open: 7

Field staff are continually auditing providers and providing technical assistance to EMS around the State.

302 West Washington Street Room E-241 Indianapolis, IN 46204 P. 317.232.2222 F. 317.233.0307
www.in.gov/dhs

Attachment #8

EMS COMMISSION CERTIFICATION REPORT

Compiled: June 18, 2014

CERTIFICATIONS (6/18/2014)	Total # of Certs	Highest Lvl. Cert
EMS - PARAMEDIC	4124	4124
EMT - INTERMEDIATE	148	124
EMS - ADVACNED EMT *(new)*	~~130~~ 133	~~130~~ 133
EMT - ADVANCED	1223	1058
EMS - EMT	19548	14162
EMS - EMR	5574	5239
EMT - PI	501	N/A
TOTAL:	31248	24837

Q1 - 2014	Count
EMS - PARAMEDIC	68
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	~~44~~ 41
EMT - BASIC ADVANCED	0
EMS - EMT	171
EMS - EMR	88
EMT - PI	7
TOTAL:	378

Q2 - 2014	Count
EMS - PARAMEDIC	0
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	0
EMS - EMT	0
EMS - EMR	0
EMT - PI	0
TOTAL:	0

Q3 - 2014	Count
EMS - PARAMEDIC	0
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	0
EMS - EMT	0
EMS - EMR	0
EMT - PI	0
TOTAL:	0

Q4 - 2014	Count
EMS - PARAMEDIC	0
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	0
EMS - EMT	0
EMS - EMR	0
EMT - PI	0
TOTAL:	0

Q1 - 2013	Count
EMS - PARAMEDIC	97
EMT - INTERMEDIATE	2
EMS - ADVACNED EMT (new)	0
EMT - BASIC ADVANCED	18
EMS - EMT	372
EMS - EMR	198
EMT - PI	8
TOTAL:	695

Q2 - 2013	Count
EMS - PARAMEDIC	24
EMT - INTERMEDIATE	2
EMS - ADVACNED EMT *(new)*	2
EMT - BASIC ADVANCED	14
EMS - EMT	525
EMS - EMR	209
EMT - PI	3
TOTAL:	779

Q3 - 2013	Count
EMS - PARAMEDIC	76
EMT - INTERMEDIATE	1
EMS - ADVACNED EMT *(new)*	11
EMT - BASIC ADVANCED	1
EMS - EMT	464
EMS - EMR	93
EMT - PI	15
TOTAL:	661

Q4 - 2013	Count
EMS - PARAMEDIC	74
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	15
EMT - BASIC ADVANCED	0
EMS - EMT	391
EMS - EMR	226
EMT - PI	6
TOTAL:	712

Q1 - 2012	Count
EMS - PARAMEDIC	119
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	43
EMS - EMT	574
EMS - EMR	158
EMT - PI	11
TOTAL:	905

Q2 - 2012	Count
EMS - PARAMEDIC	92
EMT - INTERMEDIATE	7
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	58
EMS - EMT	523
EMS - EMR	199
EMT - PI	12
TOTAL:	891

Q3 - 2012	Count
EMS - PARAMEDIC	111
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	52
EMS - EMT	492
EMS - EMR	144
EMT - PI	4
TOTAL:	803

Q4 - 2012	Count
EMS - PARAMEDIC	79
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	13
EMS - EMT	268
EMS - EMR	124
EMT - PI	13
TOTAL:	497

Emergency Medical Services
Provider Certification Report

Date : June 17, 2014 **June 20, 2014**

In compliance with the Rules and Regulations for the operation and administration of Emergency Medical Services, this report is respectfully submit to the Commission at the **June 20, 2014** Commission meeting, the following report of agencies who have meet the requirements for certification as Emergency Medical Service Providers and their vehicles.

Provider Level	Counts
Rescue Squad Organization	6
Basic Life Support Non-Transport	424
Ambulance Service Provider	102
EMT Basic-Advanced Organization	32
EMT Basic-Advanced Organization non-transport	21
EMT Intermediate Organization	4
EMT Intermediate Organization non-transport	0
Paramedic Organization	187
Paramedic Organization non-transport	10
Rotorcraft Air Ambulance	13
Fixed Wing Air Ambulance	3
Total Count:	802

New Providers Since 26-APR-14

Lakeshore EMS	**Paramedic Certification: 05/16/2014**

Emergency Medical Services
Provider Certification Report

Date : June 17, 2014 **June 20, 2014**

In compliance with the Rules and Regulations for the operation and administration of Emergency Medical Services, this report is respectfully submit to the Commission at the **June 20, 2014** Commission meeting, the following report of agencies who have meet the requirements for certification as Emergency Medical Service Providers and their vehicles.

Securitas Security Services USA, Inc.	**Basic Certification: 05/20/2014**

Attachment #9

Pass/Fail Report

Report Date: 6/19/2014 8:07:54 AM
Report Type: Program Report (IN)
Registration Level: EMT-Paramedic / Paramedic
Course Completion Date: 6/1/2013 to 6/1/2014
Training Program: All

Program Name	Program Code	Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
Adams Memorial Hospital	IN-4201	14	57% (8 / 14)	86% (12 / 14)	86% (12 / 14)	0% (0 / 14)	14% (2 / 14)	0% (0 / 14)
Community Health Network EMS	IN-4063	18	78% (14 / 18)	94% (17 / 18)	94% (17 / 18)	0% (0 / 18)	6% (1 / 18)	0% (0 / 18)
Elkhart General Hospital	IN-4067	18	61% (11 / 18)	72% (13 / 18)	72% (13 / 18)	0% (0 / 18)	28% (5 / 18)	0% (0 / 18)
Franciscan Saint Anthony Health Crown Point	IN-4079	24	33% (8 / 24)	75% (18 / 24)	79% (19 / 24)	0% (0 / 24)	21% (5 / 24)	0% (0 / 24)
Indiana University Health	IN-4062	10	100% (10 / 10)	100% (10 / 10)	100% (10 / 10)	0% (0 / 10)	0% (0 / 10)	0% (0 / 10)
Indiana University Health Goshen Hospital	IN-4162	5	40% (2 / 5)	100% (5 / 5)	100% (5 / 5)	0% (0 / 5)	0% (0 / 5)	0% (0 / 5)
Ivy Tech Community College - Madison	IN-4542	11	82% (9 / 11)	91% (10 / 11)	91% (10 / 11)	0% (0 / 11)	9% (1 / 11)	0% (0 / 11)
Ivy Tech Community College Columbus	IN-4073	11	91% (10 / 11)	100% (11 / 11)	100% (11 / 11)	0% (0 / 11)	0% (0 / 11)	0% (0 / 11)
Ivy Tech Community College Northeast	IN-4169	14	43% (6 / 14)	57% (8 / 14)	57% (8 / 14)	0% (0 / 14)	43% (6 / 14)	0% (0 / 14)
Ivy Tech Community College	IN-4501	4	50% (2 / 4)	75% (3 / 4)	75% (3 / 4)	0% (0 / 4)	25% (1 / 4)	0% (0 / 4)

Richmond								
Ivy Tech Community College Terre Haute	IN-4612	13	38% (5 / 13)	38% (5 / 13)	38% (5 / 13)	0% (0 / 13)	62% (8 / 13)	0% (0 / 13)
Ivy Tech Community College-Evansville	IN-4141	13	38% (5 / 13)	54% (7 / 13)	54% (7 / 13)	0% (0 / 13)	46% (6 / 13)	0% (0 / 13)
Ivy Tech Community College-Kokomo	IN-4362	11	73% (8 / 11)	82% (9 / 11)	82% (9 / 11)	0% (0 / 11)	18% (2 / 11)	0% (0 / 11)
Ivy Tech South Bend	IN-4070	10	60% (6 / 10)	70% (7 / 10)	70% (7 / 10)	0% (0 / 10)	30% (3 / 10)	0% (0 / 10)
Methodist Hospitals	IN-4072	7	86% (6 / 7)	86% (6 / 7)	86% (6 / 7)	0% (0 / 7)	14% (1 / 7)	0% (0 / 7)
Pelham Training	IN-4668	52	73% (38 / 52)	79% (41 / 52)	79% (41 / 52)	0% (0 / 52)	21% (11 / 52)	0% (0 / 52)
St Francis Hospital	IN-4080	6	100% (6 / 6)	100% (6 / 6)	100% (6 / 6)	0% (0 / 6)	0% (0 / 6)	0% (0 / 6)
St Mary Medical Center/Hobart	IN-4943	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
St Vincent Hospital	IN-4081	11	100% (11 / 11)	100% (11 / 11)	100% (11 / 11)	0% (0 / 11)	0% (0 / 11)	0% (0 / 11)
Vincennes University	IN-4153	15	60% (9 / 15)	73% (11 / 15)	73% (11 / 15)	0% (0 / 15)	27% (4 / 15)	0% (0 / 15)
Wishard Health Services	IN-4083	26	92% (24 / 26)	100% (26 / 26)	100% (26 / 26)	0% (0 / 26)	0% (0 / 26)	0% (0 / 26)

Attempted the exam: Number of graduates that make at least one attempt at the exam.
First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.
Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.
Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.
Failed all 6 attempts: Number and percent of those who fail the exam six times.
Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)
Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 6/19/2014 8:08:31 AM
Report Type: Program Report (IN)
Registration Level: EMT-Paramedic / Paramedic
Course Completion Date: 6/1/2012 to 6/1/2014
Training Program: All

Program Name	Program Code	Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
Adams Memorial Hospital	IN-4201	23	61% (14 / 23)	87% (20 / 23)	91% (21 / 23)	0% (0 / 23)	9% (2 / 23)	0% (0 / 23)
Community Health Network EMS	IN-4063	37	70% (26 / 37)	86% (32 / 37)	86% (32 / 37)	0% (0 / 37)	14% (5 / 37)	0% (0 / 37)
Elkhart General Hospital	IN-4067	44	59% (26 / 44)	75% (33 / 44)	82% (36 / 44)	5% (2 / 44)	14% (6 / 44)	0% (0 / 44)
Franciscan Saint Anthony Health Crown Point	IN-4079	31	32% (10 / 31)	71% (22 / 31)	77% (24 / 31)	3% (1 / 31)	16% (5 / 31)	3% (1 / 31)
Franciscan St Elizabeth Health	IN-4068	3	100% (3 / 3)	100% (3 / 3)	100% (3 / 3)	0% (0 / 3)	0% (0 / 3)	0% (0 / 3)
Hendricks Regional Health	IN-4380	13	92% (12 / 13)	100% (13 / 13)	100% (13 / 13)	0% (0 / 13)	0% (0 / 13)	0% (0 / 13)
Indiana University Health	IN-4062	15	87% (13 / 15)	93% (14 / 15)	93% (14 / 15)	0% (0 / 15)	7% (1 / 15)	0% (0 / 15)
Indiana University Health Goshen Hospital	IN-4162	5	40% (2 / 5)	100% (5 / 5)	100% (5 / 5)	0% (0 / 5)	0% (0 / 5)	0% (0 / 5)
Ivy Tech Bloomington	IN-4071	7	14% (1 / 7)	29% (2 / 7)	29% (2 / 7)	0% (0 / 7)	57% (4 / 7)	14% (1 / 7)
Ivy Tech Community College - Madison	IN-4542	11	82% (9 / 11)	91% (10 / 11)	91% (10 / 11)	0% (0 / 11)	9% (1 / 11)	0% (0 / 11)
Ivy Tech Community College	IN-4073	25	84% (21 / 25)	100% (25 / 25)	100% (25 / 25)	0% (0 / 25)	0% (0 / 25)	0% (0 / 25)

Columbus Ivy Tech Community College Northeast	IN-4169	27	37% (10 / 27)	48% (13 / 27)	48% (13 / 27)	0% (0 / 27)	52% (14 / 27)	0% (0 / 27)
Ivy Tech Community College Richmond	IN-4501	4	50% (2 / 4)	75% (3 / 4)	75% (3 / 4)	0% (0 / 4)	25% (1 / 4)	0% (0 / 4)
Ivy Tech Community College Terre Haute	IN-4612	25	36% (9 / 25)	44% (11 / 25)	44% (11 / 25)	0% (0 / 25)	56% (14 / 25)	0% (0 / 25)
Ivy Tech Community College-Evansville	IN-4141	24	50% (12 / 24)	63% (15 / 24)	67% (16 / 24)	0% (0 / 24)	33% (8 / 24)	0% (0 / 24)
Ivy Tech Community College-Kokomo	IN-4362	21	67% (14 / 21)	81% (17 / 21)	81% (17 / 21)	0% (0 / 21)	19% (4 / 21)	0% (0 / 21)
Ivy Tech South Bend	IN-4070	18	50% (9 / 18)	61% (11 / 18)	61% (11 / 18)	0% (0 / 18)	39% (7 / 18)	0% (0 / 18)
Methodist Hospitals	IN-4072	21	71% (15 / 21)	90% (19 / 21)	90% (19 / 21)	0% (0 / 21)	10% (2 / 21)	0% (0 / 21)
Pelham Training	IN-4668	117	77% (90 / 117)	88% (103 / 117)	89% (104 / 117)	1% (1 / 117)	11% (13 / 117)	0% (0 / 117)
St Francis Hospital	IN-4080	11	91% (10 / 11)	100% (11 / 11)	100% (11 / 11)	0% (0 / 11)	0% (0 / 11)	0% (0 / 11)
St Mary Medical Center/Hobart	IN-4943	13	54% (7 / 13)	77% (10 / 13)	77% (10 / 13)	0% (0 / 13)	8% (1 / 13)	15% (2 / 13)
St Vincent Hospital	IN-4081	24	100% (24 / 24)	100% (24 / 24)	100% (24 / 24)	0% (0 / 24)	0% (0 / 24)	0% (0 / 24)
Vincennes University	IN-4153	20	55% (11 / 20)	70% (14 / 20)	75% (15 / 20)	5% (1 / 20)	20% (4 / 20)	0% (0 / 20)
Wishard Health Services	IN-4083	47	91% (43 / 47)	98% (46 / 47)	98% (46 / 47)	0% (0 / 47)	2% (1 / 47)	0% (0 / 47)

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Failed all 6 attempts: Number and percent of those who fail the exam six times.
Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Pass/Fail Report

Report Date: 6/19/2014 8:04:11 AM
Report Type: Program Report (IN)
Registration Level: Advanced EMT (AEMT)
Course Completion Date: 6/1/2013 to 6/1/2014
Training Program: All

Program Name	Program Code	Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
Adams Memorial Hospital	IN-4201	6	83% (5 / 6)	83% (5 / 6)	83% (5 / 6)	0% (0 / 6)	17% (1 / 6)	0% (0 / 6)
Alliance EMS	IN-5293	6	67% (4 / 6)	67% (4 / 6)	67% (4 / 6)	0% (0 / 6)	33% (2 / 6)	0% (0 / 6)
Ball Memorial Hospital	IN-4369	16	38% (6 / 16)	44% (7 / 16)	44% (7 / 16)	0% (0 / 16)	56% (9 / 16)	0% (0 / 16)
Deaconess Hospital	IN-4516	6	67% (4 / 6)	100% (6 / 6)	100% (6 / 6)	0% (0 / 6)	0% (0 / 6)	0% (0 / 6)
Dearborn County Hospital	IN-4065	7	71% (5 / 7)	71% (5 / 7)	71% (5 / 7)	0% (0 / 7)	29% (2 / 7)	0% (0 / 7)
Harrison County Hospital EMS	IN-4336	9	89% (8 / 9)	89% (8 / 9)	89% (8 / 9)	0% (0 / 9)	11% (1 / 9)	0% (0 / 9)
Indiana University Health Goshen Hospital	IN-4162	9	33% (3 / 9)	44% (4 / 9)	44% (4 / 9)	0% (0 / 9)	56% (5 / 9)	0% (0 / 9)
Ivy Tech Community College Northeast	IN-4169	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Ivy Tech South Bend	IN-4070	20	50% (10 / 20)	65% (13 / 20)	65% (13 / 20)	0% (0 / 20)	35% (7 / 20)	0% (0 / 20)
Jennings County Training Institution	IN-5281	3	67% (2 / 3)	100% (3 / 3)	100% (3 / 3)	0% (0 / 3)	0% (0 / 3)	0% (0 / 3)
Margaret Mary Community Hospital	IN-4084	2	50% (1 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	50% (1 / 2)	0% (0 / 2)
Memorial Hospital	IN-4157	40	58% (23 / 40)	63% (25 / 40)	65% (26 / 40)	0% (0 / 40)	35% (14 / 40)	0% (0 / 40)
Memorial Hospital/Jasper	IN-5271	6	33% (2 / 6)	50% (3 / 6)	50% (3 / 6)	0% (0 / 6)	50% (3 / 6)	0% (0 / 6)
North Webster								

Tippecanoe Township EMS Ed	IN-5311	30	57% (17 / 30)	67% (20 / 30)	67% (20 / 30)	0% (0 / 30)	33% (10 / 30)	0% (0 / 30)
Parkview Huntington Hospital EMS	IN-5269	53	60% (32 / 53)	72% (38 / 53)	74% (39 / 53)	0% (0 / 53)	26% (14 / 53)	0% (0 / 53)
Parkview Regional Medical Center	IN-5296	16	63% (10 / 16)	88% (14 / 16)	88% (14 / 16)	0% (0 / 16)	13% (2 / 16)	0% (0 / 16)
Pelham Training	IN-4668	5	0% (0 / 5)	40% (2 / 5)	40% (2 / 5)	0% (0 / 5)	60% (3 / 5)	0% (0 / 5)
Prompt Ambulance Central	IN-5138	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Scott County EMS	IN-4078	5	60% (3 / 5)	60% (3 / 5)	60% (3 / 5)	0% (0 / 5)	40% (2 / 5)	0% (0 / 5)
St Joseph's Regional Med Ctr-Plymouth	IN-5001	2	50% (1 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	50% (1 / 2)	0% (0 / 2)
Sullivan County Community Hospital	IN-5193	3	33% (1 / 3)	33% (1 / 3)	33% (1 / 3)	0% (0 / 3)	67% (2 / 3)	0% (0 / 3)
Terre Haute Regional Hospital	IN-4152	4	0% (0 / 4)	0% (0 / 4)	0% (0 / 4)	0% (0 / 4)	100% (4 / 4)	0% (0 / 4)

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Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.
Failed all 6 attempts: Number and percent of those who fail the exam six times.
Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)
Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 6/19/2014 8:05:31 AM
Report Type: Program Report (IN)
Registration Level: Advanced EMT (AEMT)
Course Completion Date: 6/1/2012 to 6/1/2014
Training Program: All

Program Name	Program Code	Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
Adams Memorial Hospital	IN-4201	6	83% (5 / 6)	83% (5 / 6)	83% (5 / 6)	0% (0 / 6)	17% (1 / 6)	0% (0 / 6)
Alliance EMS	IN-5293	6	67% (4 / 6)	67% (4 / 6)	67% (4 / 6)	0% (0 / 6)	33% (2 / 6)	0% (0 / 6)
Ball Memorial Hospital	IN-4369	18	39% (7 / 18)	50% (9 / 18)	50% (9 / 18)	0% (0 / 18)	50% (9 / 18)	0% (0 / 18)
Deaconess Hospital	IN-4516	6	67% (4 / 6)	100% (6 / 6)	100% (6 / 6)	0% (0 / 6)	0% (0 / 6)	0% (0 / 6)
Dearborn County Hospital	IN-4065	7	71% (5 / 7)	71% (5 / 7)	71% (5 / 7)	0% (0 / 7)	29% (2 / 7)	0% (0 / 7)
Harrison County Hospital EMS	IN-4336	9	89% (8 / 9)	89% (8 / 9)	89% (8 / 9)	0% (0 / 9)	11% (1 / 9)	0% (0 / 9)
Indiana University Health Goshen Hospital	IN-4162	9	33% (3 / 9)	44% (4 / 9)	44% (4 / 9)	0% (0 / 9)	56% (5 / 9)	0% (0 / 9)
Ivy Tech Community College	IN-4864	1	0% (0 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Ivy Tech Community College Northeast	IN-4169	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Ivy Tech South Bend	IN-4070	22	45% (10 / 22)	64% (14 / 22)	64% (14 / 22)	0% (0 / 22)	36% (8 / 22)	0% (0 / 22)
Jennings County Training Institution	IN-5281	3	67% (2 / 3)	100% (3 / 3)	100% (3 / 3)	0% (0 / 3)	0% (0 / 3)	0% (0 / 3)
Margaret Mary Community Hospital	IN-4084	2	50% (1 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	50% (1 / 2)	0% (0 / 2)
Memorial Hospital	IN-4157	40	58% (23 / 40)	63% (25 / 40)	65% (26 / 40)	0% (0 / 40)	35% (14 / 40)	0% (0 / 40)

Memorial Hospital/Jasper	IN-5271	6	33% (2 / 6)	50% (3 / 6)	50% (3 / 6)	0% (0 / 6)	50% (3 / 6)	0% (0 / 6)
North Webster Tippecanoe Township EMS Ed	IN-5311	30	57% (17 / 30)	67% (20 / 30)	67% (20 / 30)	0% (0 / 30)	33% (10 / 30)	0% (0 / 30)
Parkview Huntington Hospital EMS	IN-5269	53	60% (32 / 53)	72% (38 / 53)	74% (39 / 53)	0% (0 / 53)	26% (14 / 53)	0% (0 / 53)
Parkview Regional Medical Center	IN-5296	16	63% (10 / 16)	88% (14 / 16)	88% (14 / 16)	0% (0 / 16)	13% (2 / 16)	0% (0 / 16)
Pelham Training	IN-4668	5	0% (0 / 5)	40% (2 / 5)	40% (2 / 5)	0% (0 / 5)	60% (3 / 5)	0% (0 / 5)
Prompt Ambulance Central	IN-5138	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Scott County EMS	IN-4078	10	50% (5 / 10)	60% (6 / 10)	60% (6 / 10)	0% (0 / 10)	40% (4 / 10)	0% (0 / 10)
St Joseph's Regional Med Ctr-Plymouth	IN-5001	2	50% (1 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	50% (1 / 2)	0% (0 / 2)
St Mary Medical Center/Hobart	IN-4943	16	38% (6 / 16)	44% (7 / 16)	44% (7 / 16)	0% (0 / 16)	56% (9 / 16)	0% (0 / 16)
Sullivan County Community Hospital	IN-5193	3	33% (1 / 3)	33% (1 / 3)	33% (1 / 3)	0% (0 / 3)	67% (2 / 3)	0% (0 / 3)
Switzerland County EMS Inc.	IN-4145	8	25% (2 / 8)	50% (4 / 8)	50% (4 / 8)	0% (0 / 8)	50% (4 / 8)	0% (0 / 8)
Terre Haute Regional Hospital	IN-4152	4	0% (0 / 4)	0% (0 / 4)	0% (0 / 4)	0% (0 / 4)	100% (4 / 4)	0% (0 / 4)
Tri County Ambulance	IN-4644	10	40% (4 / 10)	40% (4 / 10)	50% (5 / 10)	0% (0 / 10)	50% (5 / 10)	0% (0 / 10)
Vincennes University	IN-4153	4	0% (0 / 4)	25% (1 / 4)	25% (1 / 4)	0% (0 / 4)	75% (3 / 4)	0% (0 / 4)

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Failed all 6 attempts: Number and percent of those who fail the exam six times.
Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest

Pass/Fail Report

Report Date: 6/17/2014 2:30:28 PM
Report Type: State Report (IN)
Registration Level: Advanced EMT (AEMT)
Course Completion Date: 1st Quarter 2012 to 2nd Quarter 2014
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
293	52% (151 / 293)	63% (184 / 293)	64% (187 / 293)	0% (0 / 293)	36% (106 / 293)	0% (0 / 293)

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Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)
Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)